Maternal and Child Health Services
Title V Block Grant

State Narrative for Nebraska

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications, signed by the CEO, Nebraska Department of Health and Human Services (DHHS), are maintained in the administrative files for Nebraska Title V/MCH Block Grant located in DHHS, Division of Public Health, Lifespan Health Services, Planning & Support. The documents may be inspected by contacting the Title V/MCH Grant Administrator, (402) 471-0197 during regular business hours Monday-Friday, 8:00 a.m.-5:00 p.m. Central Standard Time, or sending a written request to Nebraska Department of Health and Human Services, Division of Public Health, Lifespan Health Services, Planning & Support, P.O. Box 95026, Lincoln, Nebraska 68509-5026.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input for the new priorities and the 2011 application was sought using a new process that took a more personalized approach to elicit input. An email bulletin was sent to 6,015 people who subscribe to the Nebraska Department of Health and Human Services (DHHS) website. The quantity and quality of the responses provided good evaluation that this method was an improvement from previous years, and worked quite well.

Electronic subscriptions are available on many of the DHHS program sites. Subscribers automatically receive a notice whenever a webpage has been updated and the link to the webpage. The distribution list created for the public input request targeted the persons who have requested subscriptions to web pages containing content relevant to the MCH/CSHCN priorities.

The bulletin was sent to the following groups of people:
Subscribers of Community-Based Services (Developmental Disabilities), Advocacy, Alcohol and Substance Abuse, Child Abuse, Children's Health System, Developmental Disabilities, Health Services, Lifespan Health, Tobacco/Chew/Secondhand Smoke, Access Newsletter (Office of Rural Health), Adolescent Health, Advisory Committee on Developmental Disabilities, Building Bridges - For You, For Now, For Life, COMPASS - Protection & Safety Statistics for Children, Child Abuse General Information, Child Care, Children with Disabilities, Communicable Diseases, Connections Employee Newsletter, Conversations for a Healthy Life (Office of Women's Health), Dental Health, Diabetes Prevention and Control Program, Diet, Nutrition and Eating Right, Division of Children & Family Services - Comprehensive Quality Improvement, Domestic Violence, Every Woman Matters, Every Woman Matters - Case Managers, Every Woman Matters - Outreach Workers, Every Woman Matters - Providers, Every Woman Matters.

The email addresses of subscribers to the preceding web pages provided the DHHS webmaster with a large, yet targeted group to personally invite public input. While the distribution list was very large, it was not impersonal. The email bulletin did not display to recipients the entire list of the 6,015 email addresses.

DHHS Communications assisted Lifespan Health staff to develop a clear, concise message. The reference line in the email was directive, yet inviting: "Help improve the health of Nebraska's mothers and children. Please share your thoughts". The text of the email read: "You are subscribed to Nebraska Department of Health and Human Services Website. Take a moment and share your thoughts on new priorities for mother and child health program activities. We want to hear from you! Please follow the link below.
http://www.dhhs.ne.gov/LifespanHealth/planning/MCHGrantPublicInput2010.htm"

The responses began arriving within a few hours after the email bulletin was sent. A steady stream of public input followed for the next three weeks. There were 962 hits to the public input webpage during a four-week period. A total of 34 persons responded. Most of the responses were sent by email, with one fax and two phone calls. Some responses were quite detailed and specific to one or several priorities, including some suggestions about how to address a priority. Three responders voiced their general support for the priorities identified by the stakeholder group. Three persons added their own suggestions on other issues of importance to MCH and CSHCN that the stakeholder group and workgroup process had not elevated to the top ten priorities, such as mental health and depression, tobacco use and exposure, and eating disorders. Two responses included the importance of education and utilizing available resources towards prevention, three persons expressed concern with issues related to large systems and change in systems or staff contacts within the system. Of the responders that focused on specific priorities, support for breastfeeding exclusively through six months garnered the largest number at 15 responses, with the next largest of four responses to increase access to oral health.

The responses that related were incorporated into the national and state performance measures of this application (breastfeeding and oral health). All comments will continue to be reviewed and incorporated into detailed planning for the ensuing five years of the 2010 needs assessment.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

In 2009/2010 Nebraska's Needs Assessment Committee (NAC) utilized methods and described in the University of California at San Francisco Family Health Outcome Project (FHOP) "Developing an Effective MCH Planning Process: A Guide for Local MCH Programs" to conduct a Needs Assessment of the MCH/CSHCN populations. The steps followed by the NAC were:

1. Steps in Assessing Strengths and Needs
2. Data collection and analysis
3. Present process to NAC
4. NAC develops criteria by consensus
5. NAC determines weights for each criterion
6. Staff finalizes definitions and develops rating scales for criteria
7. Subcommittee meeting 1: provide orientation, and present data
8. Subcommittee meeting 2: Review data, identify list of needs and experience in applying criteria to determine
   top 3-5 needs.
9. Subcommittee meeting 3: Write problem statements and draft factsheets, determine presenters.
10. Presentation of identified problems by subcommittees to the larger NAC
11. Use weighted criteria to score problems
12. Sum participant's scores / rank problems
13. Discuss and confirm results through consensus process
14. Finalize list of 10 priorities

This process resulted in the following 10 priority needs:

1. Reduce the rates of overweight women, youth, and children by increasing participation in Increase the prevalence of the MCH/CSHCN population who are physically active, eating healthy, and are at a healthy weight.

2. Improve the reproductive health of youth and women by decreasing the rates of STD's and unintended pregnancies.

3.Reduce the impact of poverty on infants/children including food insecurity.

4. Reduce the health disparities gap in infant health status and outcomes.

5. Increase access to oral health care for children and CSHCN.

6. Reduce the rates of abuse and neglect of infants and CSHCN.

7. Reduce alcohol use and binge drinking among youth.

8. Increase quality of and access to perinatal health services, including pre/interconception health care, prenatal care, labor and delivery services, and postpartum care.

9. Increase the prevalence of infants who breastfeed exclusively through six months of age.

10. Increase access to Medical Homes for CSHCN particularly for those with functional limitations.

Concurrently staff conducted a Capacity Assessment to determine Nebraska's capacity to provides services and then to analyze the capacity to address the 10 priorities.

III. State Overview

A. Overview

This overview describes the principal characteristics of Nebraska that are important to understanding the health needs of the entire state's population.

a. Large geographic area

Nebraska is located in the east-central area of the Great Plains midway between New York and San Francisco. Nebraska is generally rectangular in shape with a protruding area in the northwest corner called the Panhandle. The Missouri River bounds the eastern border between Nebraska and Iowa. Missouri, Kansas, Colorado, Wyoming and South Dakota surround Nebraska on the other borders. The State measures 387 miles across, including the western panhandle. The diagonal from northwest to southeast measures 459 miles, and the southwest-northeast diagonal is 285 miles. The state's area is 77,227 square miles, almost 20% larger than all of New England.

Nebraska's large land expanse creates unique health service delivery issues. In Nebraska, 13.5% of the population is 65 and over, however in 46 counties, the number of persons over age 65 exceeds 20%. This trend has important implications for the delivery of health and medical services because an older population needs more services.

Nebraska's population centers are Omaha, Lincoln and several smaller cities scattered along the Platte River and Interstate 80 (which together bisect the state from east to west). Only Omaha and Lincoln (60 miles apart) represent Metropolitan Statistical Areas (MSAs) with populations larger than 50,000.

b. Urban and rural

The total population of NE is projected to grow 7.4% by 2025. Although Nebraska's total population has grown during the 2000s, many small rural counties that are not near a regional economic or health center continue to decrease in size. Most of the decrease in these counties resulted from out-migration of the younger population (18 to 45 years). Smaller population bases make it more difficult to recruit and retain physicians and other health care professionals. A small population base also makes it more difficult to operate institutional services, such as hospitals, and finance other types of services such as mental health, public health, emergency medical services, and long-term care services.

Nebraska's geography shows the state to be a primarily rural and sparsely populated state by national standards, with 28 out of 93 counties as frontier counties (6 or fewer persons per square mile). In contrast, approximately 52.6% of the state's citizens reside in the population centers of Lincoln and Omaha in the eastern part of the state. The urbanization of Douglas and Sarpy County (Omaha), and Lancaster County (Lincoln) is represented by an average population increase of over 13% between 2000 and 2009.

c. Increasing diversity

Another source of change is Nebraska's rapidly increasing diversity in a state previously regarded as homogeneous. Nebraska currently has its highest percentage of foreign-born residents since the 1870's. Minority populations are growing rapidly in both urban and rural parts of Nebraska. According to the US Census, from 2000 to 2009 the state's minority population grew by 39% (from 197,794 to 273,365) and now constitutes 15.4% of the total population while the white population increased by .148%. Most of this increase in minorities is Hispanic, whose numbers increased 59%, 54% of the state's overall population increase.

In general, the minority population tends to be younger, have lower incomes, higher poverty, and less insurance coverage. They are also more likely to be employed in high-risk occupations such as meat packing plants and farm labor. As a result, these population groups often experience difficulty gaining timely access to health and medical services. Even when services are available,

language and cultural barriers prevent effective utilization of these services. There is a need to optimize these services for minority populations using culturally sensitive tools.

Nebraska's vision of healthy individuals, families and communities can only occur if racial and ethnic minority populations have equal opportunities for good health. To bridge the gap between the wide disparities in the health status of racial/ethnic minorities and the white population, it is essential to address the high risk factor prevalence, the major barriers that limit access to high quality health care services, and the need to develop effective local public health services across the state.

(1) Immigration
(a) Hispanic origin
The largest minority group in the state is the Hispanic American population which experienced the most dramatic increase nearly quadrupling from 37,200 in 1990 to 147,984 in 2009 (a 298% increase) according to the U.S. Census estimates. Hispanic Americans now comprise 8.3% of the state's population.

The Hispanic American population in Nebraska was projected to reach 111,000 by 2025, but has already exceeded the projection by 34% in 2009. This is largely due to the availability of employment in the central and western part of Nebraska. Hispanic Americans make up less than 10% of the population in most non-metropolitan counties, the exceptions being found in those counties with larger population centers and a sizable manufacturing base. In those places where the manufacturing base includes food processing, the population commonly exceeds 30% of the county population, and form a majority within several communities.

(b) Asian and Pacific Islander
Nebraska's Asian and Pacific Islander (API) population in 1990 was 12,629 and grew to 30,509 in 2009, according to the U.S. Census Bureau estimates.

(2) Native American
The Native American population in Nebraska grew by 62%, from 12,874 in 1990 to 19,999 in 2009, according to the U.S. Census estimates. Thurston County, home of the Omaha and Winnebago Tribes, ranks number 26 in the U.S. for percentage Native American. Over half of the county's population is Native American (53%). Four federally recognized Native American tribes are headquartered in Nebraska, the Santee Sioux, Omaha, Winnebago, and Ponca. The Native American population is expected to increase considerably by 2025. Nebraska's Native American population will increase to 25,000 people, an increase of 25%.

Though many of Nebraska's Native Americans live on reservations, the majority does not. The urban areas of Omaha and Lincoln account for more than 31.1% of the state's Native American population, although they make up only a small proportion of these counties' total populations. A sizable group also exists in the northwestern part of NE adjoining the Pine Ridge Reservation in South Dakota. Among the state's reservations, the Winnebago and Omaha reservations in Thurston County account for 22% of Nebraska's Native American population. An additional 3% reside at the Santee Sioux Indian Reservation in Knox County. The Iowa and the Sac and Fox Indian Reservations on the Nebraska-Kansas border account for about 1% of Nebraska's Native American's total population.

(3) African American
African Americans make up 4.6% of the Nebraska population. This population grew from 58,047 in 1990 to 83,400 in 2009, a 44% increase. Almost 90% of Nebraska's African American population is located in the most populous counties (Douglas, Sarpy and Lancaster).

The African American population is expected to increase considerably by 2025, with growth projected at 30.7% (to 109,000 people). This growth is fueled by a large number of African immigrants, particularly from Sudan and Somalia; Nebraska may have one of largest Sudanese

communities in the country.

(4) Minority Health Professionals
Cultural differences can and do present major barriers to effective health care intervention. This is especially true when health practitioners overlook, misinterpret, stereotype, or otherwise mishandle their encounters with those who might be viewed as different from them as they do their assessment, intervention, and evaluation. Health care professionals' lack of knowledge about health beliefs and practices of culturally diverse groups and problems in intercultural communication has led to significant challenges in the provision of health care services to multicultural population groups. The cultural diversity of the health care workforce itself can present problems that can disrupt the provision of services because of competing cultural values, beliefs, norms, and health practices in conflict with the traditional Western medical model.

While Nebraska has become an increasingly diverse state, its medical practitioners have not. In 2004, only about 1% of Nebraska primary care physicians were African American, although this group makes up 4.6% of the state's population. This is less than the U.S. average; approximately 4% of all US physicians are African American. In 2009, 0.4% (5/244) graduated from the University of Nebraska Medical School compared to 6.5% nationally. There were only 54 Native American primary care physicians practicing in Nebraska (0.3% of all physicians) yet they represent 1.1% of the states population. Hispanic Americans comprise 8.4% of the state's population and are the fastest growing population group, but account for only 1.1% of Nebraska primary care physicians. Asian Americans make up only 1.6% of the population of the state, but accounts for .7% of primary care physicians.

(5) Racial and ethnic health disparities
As in other states, Nebraska's minority population has many health disparities. For example, according to the US Census Bureau, projecting life expectancy for a Nebraska woman who is white is 6.6 years longer than for a Nebraska woman who is African American and nearly ten years (9.4) longer for a Nebraska woman who is Native American. African Americans have the highest rates of low-weight births and infant deaths in Nebraska. Native Americans in the state are five times more likely to die of diabetes-related causes than white persons. The CDC's "Women and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality" showed that Nebraska has one of the highest heart disease death rates in the country for African American and Native American women.

d. Aging population
Another significant trend is the aging of the state's population. In 2009, the percentage of the population aged 65 and older was 13.4%, compared to the national average of 12.8%. The total number of Nebraskans over age 65 increased by 3.6%, or by 8,435 individuals, from 1990 to 2000. Nebraska ranks 18th in the nation for percentage of population 65 years and over. The population over 65 is projected to grow 56% by 2020. In 2009, 2.2% of Nebraskan population was 85+. This is a slight increase from 2000 (16.5%). The total number of people aged 85 and over increased by 5.59 individuals, or by 1.9%.

The median age of Nebraskans increased from 33.0 in 1990 to 35.3 in 2000 and 35.8 in 2009. This trend has important implications for the delivery of health and medical services because an older population needs more services. However, a shrinking total population base reduces the number of people in the service area. The net result is that fewer health and medical services are available to meet the needs of the population. These inadequate services are further compounded by the lack of public transportation services in most rural areas of the state. As Nebraska struggles to maintain health care delivery in rural areas, services for older adults can become increasingly fragmented and challenging.

e. Special populations
(1) Incarcerated
According to Nebraska Department of Corrections there were 352 incarcerated women in

2009. 7.9% of all persons incarcerated in Nebraska were women, which is higher than the national rate of 6.8%.

According to the US Department of Justice, 61.7% of incarcerated women have at least one child under age 18. Nationally, 2.3% of the nation's children had a parent in State or Federal prison. African American children were nearly 9 times more likely to have a parent in prison than white children. Hispanic children were 3 times as likely as white children to have an inmate parent. The number of children with a mother in prison nearly doubled since 1991.

(2) Homeless
The Nebraska Homeless Assistance Program (NHAP) makes funds available to nonprofit organizations through grant awards in order to serve the needs of people who are homeless and near homeless in the state. According to NHAP data, 18,169 people were homeless in Nebraska during the grant year July 2008 to June 2009 and 43,029 people were near homeless during this same time period. Unaccompanied women accounted for 19.94% of the homeless and 7.8% of the near homeless. Unaccompanied youth accounted for 4.6% of the homeless in Nebraska and 3% of the near homeless. Single parent families accounted for 36.8% of the homeless and 49.5% of the near homeless.. During the grant year, Hispanic or Latino persons represented 33.6 % of persons who were homeless and 31.8% of those who were near homeless.

f. Rural poverty
Throughout Nebraska, poverty rates remain relatively close to the state average in each city/county. Nebraska's more rural counties demonstrated a pattern common throughout non-metropolitan Nebraska, losing population while the number of residents in poverty increased. Between 2000-2007 Small trade center counties (having a population center of 2,500 to 9,999) lost 12,700 residents while their poverty population grew by 1,581. Small town counties (having no population center of 2,500) saw their total population decline by about 10,500, while their poverty population grew by 632. Only Nebraska's very rural frontier counties (having no population center of 2,500 and fewer than 6 residents per square mile) saw an actual decrease in poverty numbers, with a decline of 295. However, those counties saw an actual population decline of over 6,000 during the same period. There are two counties in Nebraska which are experiencing critical poverty rates (at least 50% above the state average) Dawes (15.8%) and Thurston (20.5%).

2. Agency's current priorities and initiatives with Title V programs' roles and responsibilities.

A description of the Agency's priorities and initiatives first requires an understanding of changing organizational structure. During the 2007 legislative session, LB 296 was passed and signed into law by the Governor. This bill reorganized the three agencies that formerly formed the Health and Human Services System into one agency: the Department of Health and Human Services. This new structure went into effect July 1, 2007. The single agency is headed by a Chief Executive Officer. The Department has six divisions: Public Health, Behavioral Health, Children and Family Services, Developmental Disabilities, Medicaid and Long Term Care, and Veterans Homes. Title V/MCH functions are located in the Division of Public Health, Lifespan Health Services Unit. Title V/CSHCN functions are within the Division of Medicaid and Long Term Care and its Long Term Care Programs Section.

The Division of Public Health established five priority areas: wellness, eliminating disparities, data capacity, effective public education and use of the media, and budget transparency. Overlaying these established agency priorities are a number of issues that emerged in FFY 2004 and continue to be of importance to DHHS, including the Lifespan Health Services Unit and the Long Term Care Programs Section.

Child Protection Reform was initiated with the passage of LB 1089 in April 2004. This funding bill allocated $5.5 million for 120 new protection and safety workers, and another $350,000 for case coordinators. Additional funds were also made available for enhancements of the Criminal Justice

Information System and other related activities. Then, during the 2005 legislative session, LB 264 was passed, which adds secondary
prevention as a social service that may be provided on behalf of recipients under the Social Security Act. In addition, $200,000 per year was appropriated in 2005 specifically for home visitation services. Funding for home visitation as secondary prevention of child abuse and neglect is currently at $600,000 per year.

The Lifespan Health Services Unit is actively partnering with NE HHS Children and Family Services staff in addressing issues of child abuse prevention. A Child
Abuse Prevention Plan was released in August 2006, and Lifespan Health Services continues to work with NDHHS Children and Family Services and the Nebraska Children and Families Foundation in its implementation. Formalizing its commitment to child abuse prevention, the Division of Public Health signed on in 2010 as a member of the Child Abuse Prevention Partnership.

Also enacted in 2004 was enabling legislation for mental health reform. This law established the Behavioral Health Division within HHS and created a State Behavioral Health Council. The focus of this system reform effort has been to ensure statewide access to behavioral health services; ensure high quality behavioral health services; ensure cost-effective services; and ensure public safety and the health and safety of persons with behavioral health disorders. The immediate goal of the reform initiative had been the movement of behavioral health from institutional care to community-based services for persons with chronic and severe mental health disorders.

In FFY 2005, Nebraska Health and Human Services had the opportunity to do related work specific to children's mental health. Nebraska was the recipient of a 5-year, $750,000/year State Infrastructure Grant (SIG), awarded by SAMHSA, which is focused enhancing and building capacity for children's mental health services. The Lifespan Health Services Unit had been actively involved in activities of the SIG grant
through participation in its Project Management Team.

In recent years, several developments resulted in additional focus on children's mental health. LB 542 (2007) was created to parallel an emphasis on children and adolescents that LB 1083 (2004) provided for adults. LB 542 created the Children's Behavioral Health Task Force, which was charged with preparing a children's behavioral
health plan by December 4, 2007. The Children's Behavioral Health Task Force developed 16 recommendations designed to improve Nebraska's child and adolescent behavioral health system. The scope of the plan includes:

1. The development of a statewide integrated system of care to provide appropriate educational, behavioral health, substance abuse, and support services to youth and their families serving both adjudicated and non-adjudicated youth;
2. The development of community-based inpatient and sub acute substance abuse and behavioral health services and the allocation of funding for such services;
3. Strategies for effectively serving juveniles assessed in need of substance abuse or behavioral health services upon release from the Youth Rehabilitation and Treatment Centers;
4. Development of needed capacity for the provision of community-based substance abuse and behavioral health services for youth;
5.Strategies and mechanisms for the integration of federal, state, local, and other funding sources for the provision of community-based substance abuse and behavioral health services;
6. Measurable benchmarks and timelines for the development of a more comprehensive and integrated system of substance abuse and behavioral health services for youth;
7. Identification of necessary and appropriate statutory changes for consideration by the Legislature; and
8. Development of a plan for a data and information system for all youth receiving substance abuse and behavioral health services.

LB 542 also required that, "The department shall provide a written implementation and appropriations plan for the children's behavioral health plan to the Governor and the committee by January 4, 2008." That response was prepared, and the Division of Behavioral Health continues to work on the plan through a newly created Children's Behavioral Health Unit.

Then, Legislative Bill 157 was introduced in the 2008 Legislative Session. Forty-eight senators voted for the final version of LB 157. It was signed by Governor Heineman on February 13, 2008. This Safe Haven law did not provide an age limit for which a person would drop off a child at a hospital and not be prosecuted. The full text of LB 157 reads: "No person shall be prosecuted for any crime based solely upon the act of leaving a child in the custody of an employee on duty at a hospital licensed by the State of Nebraska. The hospital shall promptly contact appropriate authorities to take custody of the child."

The law went into effect on July 18, 2008. In September, families began leaving children at Nebraska hospitals, all of these children were over age 1 and several were older than age 10. A special session of the Legislature was called in November 2008, and LB 1 was introduced, passed and signed into law effective November 21, 2008. LB 1 limited the age of a child under the Safe Haven provisions to be 30 days old or younger. During the less than 6 months that LB 157 was in effect, 36 children were dropped off at Nebraska hospitals, many with complex behavioral health needs, bringing significant public attention to the mental health needs of children and youth and the systems that were to meet those needs.

During the 2009 session, the Legislature considered many options for addressing unmet children's behavioral health needs. On May 22, Gov. Dave Heineman signed LB 603 into law. The bill provides additional services, support and professional resources to help Nebraska families dealing with children's behavioral health issues. The bill helps address the gap in services for children with behavioral health issues by providing services and expertise to support children and their families. The bill included:
1) A statewide hotline for families facing a behavioral health crisis available 24/7 and staffed by professionals trained in mental health assessment;
2) A family navigator program to provide follow-up assistance and one-on-one support to families contacting the crisis hotline. Family navigators will have the experience and training to help a family access mental health services, and offer assistance to parents and guardians who may not be familiar with providers in Nebraska's behavioral health network; and
3) New services for families that adopt or serve as guardians of a child with behavioral health challenges. Case management and post-adoption services will be available on a voluntary basis. Roughly half the of the children and teens involved in 2008 safe haven cases in Nebraska had been adopted or placed in a guardianship with a relative. Studies show continuing services is effective in helping families through the transition and ensure a child's placement is a permanent.

LB 603 also took a step toward expanding services and helping more families access help by increasing the eligibility level for the State Children's Health Insurance Program (SCHIP) from 185 to 200 percent of the federal poverty level. It also adds secure residential treatment to the list of Medicaid-eligible services in Nebraska. It also provided an additional $1.5 million for the current biennium to Nebraska's six behavioral health regions to expand an existing mentoring program and support other services for children. Finally, the bill sought to encourage greater professional support in Nebraska communities. It established the Behavioral Health Workforce Education Center at the University of Nebraska Medical Center (UNMC). The center is recruiting and training more psychiatry residents and developing six behavioral health training sites across the state.

Then, in the spring of 2009, the H1N1 outbreak brought to light a number of issues, needs and challenges related to preparedness. Lifespan Health Services staff and the Title V/MCH Director participated in the emergency response. Experiences during this outbreak have lead to more specific planning regarding the role of various professionals across the Division, how

we prepare for the needs of specific populations, including MCH and CSHCHN population, and how operations are managed during an event such as an outbreak.

Medicaid reform is the priority for NDHHS Division of Medicaid and Long Term Care. Nebraska initiated Medicaid reform efforts in order to assess the current program and plan for the future. Legislation was passed in 2005 (LB 709) that established the requirements for a Medicaid reform plan. This law required that a plan be developed by December 1, 2005. As required by the law, the Governor and the chairperson of the
Health and Human Services Committee have each designated a person to be responsible for the development of the plan. The Governor's designee was the Director of Health and Human Services Finance and Support (an agency within the former Nebraska Health and Human Services System); the Legislature's designee was the General Counsel of the Nebraska Legislature's Health and Human Services Committee. A Governor-appointed 10-person council advised the process, and the Health and Human Services System provided the staffing.

As required by LB 790, the Nebraska Medicaid Reform Plan was presented to the
Governor and the Legislature on December 1, 2005. This plan included a wide range of findings, recommendations and strategies. The plan made it clear that no major changes in eligibility or benefits were being recommended at this time. The recommendations of most significance to the MCH and CSHCN populations were: establishing a separate SCHIP program (currently a Medicaid expansion); requiring a contribution from parents with incomes in excess of 150% of poverty for children participating in the Katie Beckett program, Aged and Disabled Waiver program, Children's Developmental Disability Waiver, the Early Intervention Waiver, and the State Ward Program; and including as a covered services, a nurse home visitation program for high-risk pregnant teens. Other recommendations, such as those related to prescription drugs, had potential impacts as well.

The initiatives of Medicaid reform have since been revisited with plans to implement various components. The priorities of the current administration are the standardization of services statewide, transparency and accountability of our programs, and long term the sustainability of Medicaid. The Medicaid Reform Plan proposed twenty-six initiatives intended to focus the program on its core mission to provide medical assistance for truly needy Nebraskans in a manner that promotes access to appropriate services, fosters the development and utilization of less intensive care, encourages consumer responsibility and Medicaid alternatives, and expends limited resources prudently. Several of the initiatives targeted management of prescribed drugs, as the fastest growing expenditure category, and long-term care services, as the largest expenditure category. Other initiatives emphasize the involvement of the consumer in appropriate health care utilization, the development of alternatives to Medicaid-financed care, and the alignment of program growth with available resources. Service limitations resulting from Medicaid Reform are generally being applied to Medicaid-eligible adults and should not directly impact the CSHCN population.

Initiatives of particular interest to the Children with Special Health Care Needs population include the identification of cost-effective telehealth technologies, and the expansion of home and community-based services, including the development of a premium buy-in program for children with disabilities, under a separate Medicaid Home and Community-Based Waiver for families with children with Autism Spectrum Disorder.

The Autism Waiver will request the parents of children receiving this service who have the financial means to share in the cost of the service provided to their minor child. Monthly premiums for families with income at 185% of Federal Poverty Level would begin at 1% of gross income. The premium percentage would then graduate by intervals of .25% as family income increases in relation to Federal Poverty Level. Families are charged a maximum of 5% of gross income.

Projected implementation is late summer 2010.

3. Process used to determine the importance, magnitude, value, and priority of competing factors upon the environment of health services in the State.

Beginning with the needs assessment completed in 2005, the Lifespan Health Services Unit has utilized the Family Health Outcomes Project's (FHOP's) "Developing an Effective MCH Planning Process: A Guide for Local MCH Programs." Adapted for state level planning processes, this model has been a very useful tool for not only determining priorities, but also for determining strategic directions for addressing the priorities.

In 2006, Lifespan Health Services completed an environmental scan to determine which of the then current 10 priorities were candidates for targeted strategy development. Criteria for targeting included whether a priority was being adequately addressed through existing programs or partnerships. Based on this scan, work groups were formed to conduct a formal problem analysis and to identify effective interventions for 4 of the priorities: preterm birth/low birth weight, healthy weight among women and children; transition for CSHCN, and infant mortality disparity. The first 3 listed work groups completed their work in 2008, and the infant mortality disparity work group was formed in 2009. The work groups continued to use adaptations of the FHOP model.

Largely through the findings of the preterm birth/low birth weight and healthy weight work groups, the Lifespan Health Services Unit adopted a new emphasis on a life course health development model and social determinants of health framework. Funding guidelines for community based projects, released in 2008, incorporated the model and framework, and the infant mortality disparity work group's findings have reinforced our emphasis going forward.

In addition to these processes, the Lifespan Health Services Unit has negotiated the demands of competing environmental factors by maintaining a focus on building its capacity to carry out the 10 essential public health services, both at the state level and at the community level. With flat or diminishing financial resources, it is clear that the Unit and Title V cannot be all things for all people, nor can it pay for an extensive array of services. Rather, it is in our best interest to build public health capacity, and be aggressive in developing and maintaining a wide range of public health partnerships.

In this vein, the Lifespan Health Services Unit completed an abbreviated version of the CAST-5 assessment in FFY 2005. During June 2005, the Unit also participated in the application of the State Public Health Performance Standards. This latter activity contributed to a state public health strategic plan that provides the blue print for building capacity over the next few years.

The Nebraska Public Health Improvement Plan was finalized, approved, and published in SFY 2009. The purpose of this strategic plan is to identify a new vision for public health in Nebraska and the resources that are necessary to achieve the vision. Seven major strategic directions are identified. The seven major strategies in this plan were developed by the Turning Point Public Health Stakeholders Group. This plan is intended as a guide for public health leaders, as well as state and local policymakers as they continue to strengthen and shape the public health system.

At the turn of the 21st century, when the first public health improvement plan was developed, stakeholders saw the public health system in Nebraska to be weak, fragmented, and severely underfunded. Public health services and programs were available in less than one-quarter of the counties in the state. By 2006, a major transformation had occurred. Local public health departments now cover every county and provide all of the core public health functions. The new public health infrastructure has strong leaders, exciting new partnerships, and improved funding.

Despite this success, many challenges still need to be addressed. For example, the public health workforce still needs training and education in many of the core competencies. Also, new

resources and leadership are needed to build integrated data systems that are more accessible to researchers and public health practitioners. There are also many complex problems that can only be resolved through effective collaborative partnerships. Some of these problems include access to health care services, disparities in health status between the white population and racial and ethnic minority populations, the inadequate supply of health professionals in rural areas, the dramatic increase in the number of people that are overweight and obese, the emergence of new diseases such as SARS and
West Nile Virus, and the threat of pandemic flu. To meet these challenges, the public health infrastructure will need to be strengthened and become more efficient. There is also a need to demonstrate accountability to both policymakers and the general public through the use of a more business-like model to determine the feasibility of service expansion. Finally, public health leaders must continue to build collaborative partnerships with the medical community, businesses, schools, and many others. Through these diverse partnerships, appropriate strategies can be developed and sufficient resources can be found to achieve the vision of healthy and productive individuals, families, and communities across Nebraska.

This planning document, found at http://www.dhhs.ne.gov/puh/oph/ will be an important guide and influence on Title V/MCH and CSHCN planning as we move through this decade.

Currently underway is work to develop Nebraska's 2020 Health Objectives. It is important to note that a life course health development model is informing this work, and Lifespan Health Services staff have contributed their experience in applying that model to the planning process.

4. Characteristics presenting a challenge to delivery of Title V services

Details are provided earlier in this section regarding a wide range of issues, including large geographic area, urban and rural differences, increasing diversity, racial and ethnic health disparities, an aging population, and special populations. These issues are ongoing challenges to the delivery of health and human services to Nebraska's MCH and CSHCN populations. During the 2000's, Medicaid eligibility changes had been made in response to state budget shortfalls. As a consequence, thousands of low income children and parents lost Medicaid coverage. Those reductions in coverage stressed Block Grant funded services, particularly the Medically Handicapped Children's Program, which has long been a gap filler for those children not eligible under Medicaid.

Nebraska lawmakers expressed their intent to further reduce and/or control Medicaid expenditures, with the Medicaid Reform Act requiring a plan be developed by December 1, 2005. As previously stated, this plan did not make major changes to eligibility or benefits, except for the recommendations for a separate SCHIP program and for contributions from parents for children served through certain waiver programs.

A positive development for the MCH and CSHCN population was that LB 603 signed into law in 2009 increased the income eligibility for children under age 21 to 200% of poverty through Nebraska's SCHIP. SCHIP is a Medicaid expansion in Nebraska. The income eligibility for pregnant women remained at 185% of the federal poverty level.

Practices for determining the eligibility of pregnant women were assessed and changed during FY 2010. Social services workers were counting the unborn baby in the household or even in some cases, individually, to obtain eligibility for many programs, including Medicaid. This is not a valid way to determine eligibility and the Department was advised by CMS that this practice could not continue.

Health professional shortages have been a longstanding challenge for delivering MCH services across the state. Twenty-nine of 93 counties are considered all or partially included in a Health Professional Shortage Area. State-designated shortage areas include most of Nebraska's rural

counties for a number of primary care provider types. The number of Federally Qualified Health Centers (FQHCs) is only 6, and these centers do not begin to address the vast distances some families have to travel to receive care.

Historically, Nebraska has been challenged in meeting match requirements for the Title V/MCH Block Grant at the state level, resulting in a significant dependence on local match sources. This situation has become more acute over time, as state general funds become scarcer and tobacco settlement funds are further diverted to other uses. At the same time, local match has usually included considerable amounts of Medicaid reimbursement as match. With changes in income eligibility, both increasing for children but excluding certain women, the impact on local match will be complex in the short term. The impacts of federal health care reform are yet to be fully analyzed.

An issue receiving attention in Nebraska and elsewhere is the aging of the public health work force. Success in carrying out the 10 essential public health services is dependent on an adequately trained work force. As many state and community level public health professionals retire in the next few years, the recruitment and retention of new public health workers is a concern. The relatively new University of Nebraska Medical Center's College of Public Health, is addressing this need, in part. Non-competitive compensation and limited job advancement opportunities will continue to be a deterrent to recruiting new public health professionals, especially within state government and in very rural communities.

LB 403 was a bill passed and signed into law in April 2009 and which went into effect October 1, 2009. LB 403 requires the verification of lawful presence in the United States for the receipt of public benefits. It clearly exempts emergency health care, testing and treatment of communicable diseases, immunizations, and certain short term disaster or public safety services from these verification requirements. The agency examined the implementation issues related to its programs and determined that the requirements of LB 403 applied to these programs administered by the Lifespan Health Services Unit: the Commodity Supplemental Food Program (CSFP), the Breast and Cervical Cancer Screening Program and the Colon Cancer Screening Program. All federal and state funded programs administered within the Division of Medicaid and Long-Term Care have been affected and were included under the requirements of LB403.

In summary, Nebraska's greatest challenges in providing MCH/CSHCN services are: widely and unevenly dispersed populations; increasingly diverse populations; significant health disparities among racial/ethnic minorities; shortages of health professionals primarily in rural areas; diminished financial resources; an aging public health workforce; and changing policies on eligibility for public benefits.

B. Agency Capacity

With Title V/MCH Block Grant funding remaining flat and inflation increasing costs of doing business, maintenance of agency capacity to promote the health of all mothers and children, including CSHCN, has become increasingly challenging. As indicated in the previous section, investments in infrastructure and collaborative partnerships continue to be emphasized as the most efficient means for investing the Block Grant as a means of sustaining capacity.

Community level agencies have traditionally provided a number of services that encompass all levels of the public health pyramid, but with steadily decreasing emphasis on direct services.

As noted in an earlier section, Lifespan Health Services Unit shifted its focus to a life course health development model and social determinants of health framework. A Request of Applications (RFA) issued in May 2008 incorporated this model and framework, and then focused Title V/MCH Block Grant funding at the community-level on a selected set of priority needs to concentrate efforts and maximize outcomes. Applicants were to address one and preferably no

more than three of the following public health goals and one and preferably no more than three outcomes associated with each selected goal:

PERINATAL RELATED GOALS- Reduce rates of preterm and low birth weight births; reduce rates of infant mortality; and eliminate disparities among racial/ethnic minorities for preterm and low birth weight, SIDS and other sudden unexpected infant deaths, and/or infant mortality.

ASSOCIATED PERINATAL OUTCOMES- Increased access to preventive health care for women of reproductive age; health care systems provide culturally competent preconception health care; woman at risk for or with history of poor birth outcomes receive targeted pre and interconception care; women have access to supportive networks within communities (i.e. family, faith, business/workplace, education, peer networks) to decrease stress and isolation; women of reproductive age have improved access to mental health services; women demonstrate a reduction in adverse health behaviors and an increase in healthy behaviors; Women/couples have a reproductive life plan; more women/couples have pre-pregnancy health visits; women/couples have improved health literacy as measured by their ability to understand and act on information and navigate the health system; health and human service providers deliver consistent, accurate messages on safe sleep practices for infants; and parents and other caregivers routinely provide safe sleeping environments for infants.

HEALTHY WEIGHT RELATED GOALS - Women of reproductive age are at a healthy weight, including prior to and between pregnancies; and children enter kindergarten at a healthy weight.

HEALTHY WEIGHT ASSOCIATED OUTCOMES - Health care providers use evidence-based guidelines and best/promising practices in helping women achieve and maintain a healthy weight; communities and health care systems have increased capacity to provide services to promote healthy weight among women and children; more workplaces and schools will have effective wellness policies that address nutrition and physical activity, breastfeeding support, and environmental supports for wellness; more women in school and/or workplace settings engage in healthy behaviors; and communities, through governing bodies and community leadership, adopt plans and policies to increase access to healthy foods and physical activity.

Applicants were to consider and incorporate as appropriate the following themes: 1. An emphasis on population-based, primary prevention and wellness models; 2. Social ecological model, including social determinants of health and health equity; 3. A life course approach to improving health outcomes, including the importance of preconception and inter-conception health; and 4.Importance of community-wide and system level change.

Through this competitive process, the following community-level projects were approved for the 3-year funding cycle that ends September 30, 2011:

Four Corners Health Department (Butler, Polk, Seward & York counties) - Partners with communities to promote healthy weight among children. Implements Animal Trackers curriculum in daycares/preschools. Animal Trackers increases structured physical activity time during the preschool day. Hosts Family Fun Nights to support families in physical activity and healthy eating. Enhance current activities, e.g. Concordia University's Early Childhood Education Conference, and Seward Family Fun Night. Contracts with Registered Dietitian to reach families through farmers' markets and immunization clinic.

Northeast NE Family Services (Fremont) -- Reduces the incidence of low birth weight and preterm births through enhanced family planning visits to include preconception risk assessment and reproductive health plan. Increases access to early prenatal care via Three Rivers District Health Department's Call Care Line and referral to physicians.

Goldenrod Hills Community Action, Inc. (Burt, Cuming, Dodge, Madison, Pierce & Stanton counties) - Enhances pre-existing Operation Great Start, which is non-intensive case management and home visitation service provided to low and medium risk clients for infants up to 12 weeks of age with a focus on first-time mothers. Program provides an array of supports for parents to be successful. Referral sources are Faith Regional Health Services and St. Francis Memorial Hospital and clinics, and Goldenrod Hills WIC and immunization programs. Provides teen parent education to pregnant and postpartum teens in Norfolk Public Schools. Preconception and interconception care offered to females receiving HPV immunizations.

Panhandle Public Health District (the 11 counties of the Panhandle region) - Campaigns for and supports workplace policy change and environmental supports for breastfeeding, physical activity and nutrition. Partners with clinics to assess reproductive-age women for preconception / interconception plan followed by a brief intervention at regular clinic visits.

South Heartland District Health Department (Adams, Clay, Nuckolls & Webster counties) - Assesses, trains, and supports workplaces to develop teams to implement worksite wellness policies and supports in 20 small businesses. Assists workplaces and schools to have effective wellness policies that address nutrition and physical activity, breastfeeding support, and environmental supports for wellness. The local health department partners with Mary Lanning Memorial Hospital, Well Workforce
Nebraska, and Educational Service Unit #9.

Lincoln Lancaster County Health Department (Lincoln) - Implements "A Family Approach to Prevention of Childhood Obesity" in three census tracts of Lincoln with a 34% minority population, > 25% of population is < 18 years of age, and with a high rate of poverty. Convenes community partners and resources to pilot "54321 GO" project (participants focus on achieving 5 servings of fruits and vegetables, 4 servings of water, 3 servings, of low-fat dairy products, 2 hours or less of screen time, and 1 hour or more of physical activity each day) and evaluates effectiveness of this approach.

Central Health Center (Grand Island, Kearney, and Lexington) - Reduces the incidence of low birth weight and preterm births by integrating preconception and interconception care into family planning clinic visits, developing reproductive life plans, and using information technology (My Space) to promote its program.

University of Nebraska Medical Center, Maternal Care Program (Omaha) - Expands scope of pre-existing Maternal Care Program that provides prenatal care to include pre- and inter-conception care. Adds training and continuing education for medical students, residents, and practicing physicians on life course concept to improve birth outcomes.
Actively engages local providers in Omaha who provide health care to at-risk women, e.g. Charles Drew Health Center, One World Community Health Center, and the Fred LeRoy Health and Wellness Center.

Northeast Nebraska Public Health Department (Cedar, Dixon, Thurston, Wayne counties) - Creates Northeast Nebraska Child-Fetal Infant Mortality Review Project with a Case Review Team and Community Action Team to perform death case reviews with participation from Omaha and Winnebago Tribes. Evaluates home visitation services in the district. Forms Health Literacy Council.

A separate Tribal set aside of $200,000 has been established for the four federally recognized Tribes headquartered in Nebraska. These funds may be used for either services or for infrastructure building.

Then, to assure continued investment in community-level MCH infrastructure, time-limited contracts are executed with local health departments for specific purposes. Currently, a contract with a local health district is for the purposes of piloting a public discourse model as a means for identifying and addressing community level MCH/CSHCN issues. A second contract with an urban health department focuses on addressing the quality of prenatal care and promoting preconception health through a life course health development model.

Based on the recently completed needs assessment, additional contracts with a range of Nebraska organizations will be considered to address short-term capacity issues.

State level programs receiving Title V/MCH funds that assure preventive and primary care services to pregnant women, mothers, infants, and children include: Perinatal, Child, and Adolescent Health including school health, MCH Epidemiology (which includes the Child Death Review Team and PRAMS); Newborn Screening and Genetics; Office of Health Disparities and Health Equity; Office of Women's Health; Dental Health; and Reproductive Health. In addition, the Block Grant provides partial support to the Birth Defects Registry.

Additional sources of revenue are continually being pursued to supplement state level MCH activities. Awards in recent years included a perinatal depression grant and a two newborn hearing screening grants. Though the perinatal depression grant has expired, its work products continue to be supported and promoted in collaboration with partners.

For the past 5 years, the Lifespan Health Services Unit has administered an allocation of TANF funds that provides enabling services for women who are pregnant or believe they may be pregnant. These services are provided through a contract that is competitively awarded every two years.

Late in FFY 2008, Nebraska was awarded a First Time Motherhood/New Parents Initiative grant. Nebraska's project was initially titled "Building Bridges - For You, For Now, For Life," with a project period of September 1, 2008 through September 30, 2010. Its goals are to: Increase awareness among women, ages 16-25, of the benefits of a life-course approach to pre- and inter-conception health; and increase awareness among community-based providers of the benefits of a life-course approach to pre- and inter-conception health and how to incorporate in various settings. The target audience is Nebraska women 16 -- 25 years (Millennials) who are low income and at risk of being uninsured or underinsured. Messages are being tailored for urban/rural, African American, Hispanic, and Native American women, and husbands/partners. Key activities include:

YEAR ONE -- A contractor was selected through a competitive process. The contractor used a social marketing model to develop and test a range of messages related to a life-course perspective and pre and inter-conception health based on CDC's model. The subject matter and modes of delivery were determined through focus groups and other methods. The effectiveness of the Healthy Mothers, Healthy Babies Helpline was also tested with the Millennials.

Based on this market research, TUNE was developed, and TuneMyLife.org was created. This informational campaign uses music as a means of engaging and inspiring the target audience to take control of their life and to include healthy life styles in setting their goals, including any future plans for having children. See http://www.tunemylife.org/ for more information.

Through another competitive process, a second contract was awarded to develop and deliver outreach and training to health, human services, educational providers, and faith-based providers, then deliver this training.

YEAR TWO -- TuneMyLife.org was fully launched. The training modules and tool kits for providers are being finalized, and use at statewide training events has begun. Soon, community-based organizations will be competitively selected to develop modifications needed to

incorporate new and expanded messaging within their settings, and begin creating systems supporting a life-course approach to health, including pre- and interconception health.

Plans are underway to further enhance this project, including adding additional music and messages to better reach a more diverse audience. Lifespan Health Services staff members are working with other state-level programs to incorporate messaging and social media approaches.

For CSHCN, one state-level program provides the majority of Title V-funded services to CSHCN -- the Medically Handicapped Children's Program (MHCP). Located in Medicaid Long Term Care, State and Grant Funded Programs Unit, MHCP provides or pays for specialty and sub-specialty services through agency and contracted staff from a number of hospitals and private practitioners throughout the state. Many of these professionals participate in community-based multidisciplinary team diagnostic and treatment planning clinic sessions, and they also offer medical care and follow-up medical services. Community-based medical home family physicians and pediatricians also provide follow-up services and care coordination throughout Nebraska.

In addition, MHCP operates the Disabled Children's Program (DCP) for those children eligible for SSI. The Disabled Children's Program (DCP), which is a component of MHCP, provides funding to help families care for their children with disabilities at home. A family focused assessment process determines the need for services. Some of the funded services include: respite care; mileage, meals and lodging for long-distance medical trips; special equipment and home/architectural modifications; and care of siblings while care is received by the child with a disability/special need. The Disabled Children's Program (DCP) was designed to serve children who have a special health care need, receive monthly Supplemental Service Income (SSI) checks, are 15 years of age or younger, and live at home with their families.

As the Center for Medicare and Medicaid Services grant, EPSDT Portals to Adulthood, came to an end, MHCP implemented a transition clinic (consultation) as designed by this grant. The transition clinics targeted CYSHCN seventeen to twenty-one to assist them in how to move into adulthood and mange their special health care needs and adult services. The clinics/consultation examine medical, educational, employment, housing, and all life planning aspects of becoming an adult with special health care needs.

In Nebraska, statutes pertaining to maternal and child health are found in Chapter 71, sections 2201-2208. The duties concerning the responsibility of the Nebraska Health and Human Services as to the federal early intervention program are found in 43-2509. Statutes requiring the birth defects registry are found in 71-645 through 648. Metabolic screening and associated responsibilities are found in 71-519 through 71- 524. Finally, CSFP is found at 71-2226 and WIC at 71-2227.

In 2003, LB 407 was signed into law which allocated $1,620,000 in tobacco settlement funds to the Lifespan Respite Services program for the biennium from July 1, 2003 through June 30, 2005. Use of this source of funds for respite care has allowed expansion of this service and has resulted in more MHCP funds being devoted to medical and rehabilitative services. The biennial allocations for this program have remained steady through FY 2009 -- 2011.

Nebraska continues to strive to promote and support culturally competent approaches to service delivery. Data collection and analysis, whenever possible, addresses race and ethnicity, and to a lesser degree, language. For instance, Nebraska stratifies its PRAMS data by race and ethnicity, and has obtained CDC approval to include Nebraska Native American women who deliver outside of Nebraska in its sample, to assure that these women are adequately represented in data collection. Nebraska MCH/CSHCN programs benefit from the efforts of other offices in NDHHS to collect culturally relevant data, such as the Minority Behavioral Risk Factor Survey. During the comprehensive needs assessment, analysis by cultural groups was extensively done and disparities among groups was one of the criteria used in prioritizing needs.

NDHHS has a long history of offering and promoting training in cultural competency for both its staff and stakeholders. Culture and language are frequently incorporated into the wide range of training and technical assistance activities sponsored by the Lifespan Health Services Unit for its community partners. Lifespan Health Services has a strong working relationship with the Office of Health Disparities and Health Equity (OHD&HE) and has collaborated on training events tailored for specific audiences. Currently underway is an initiative to use "Unnatural Causes" in a series of public engagement meetings. This initiative is being jointly launched by the OHD&HE, the Women's Health Council, and the Minority Health Advisory Council.

The Nebraska Minority Public Health Association is a key stakeholder and partner, with its members participating in and contributing to needs assessments and major initiatives over the years.

The Lifespan Health Services Unit has had ongoing working relationships with Northern Plains Healthy Start and Aberdeen Area Tribal Health Directors' programs, and works closely with the Native American Liaison in the Office of Health Disparities & Health Equity. Individual programs work with specific communities and community leaders in developing culturally relevant initiatives.

Since FY 2003, the Lifespan Health Services Unit maintains a set-aside of Title V funds for those federally recognized Tribes headquartered in Nebraska. This set-aside recognizes the special government-to-government relationship between NDHHS and the Tribes, as well as a priority to meet the health needs of the Native American MCH populations. In allocating funds for other community based programs, the needs of culturally diverse groups are directly addressed in the RFPs, through expectations for addressing the needs of racial and ethnic minorities and engaging representatives from culturally diverse groups in program planning and development. Further, the CLAS standards are an expectation outlined in the Title V RFP for communities and these standards are thus incorporated by reference into the awards made to community sub grantees.

C. Organizational Structure

During the 2007 legislative session, LB 296 was passed and signed into law by the Governor. This bill reorganized the three agencies that formerly formed the Health and Human Services System into one agency: the Department of Health and Human Services. This new structure went into effect July 1, 2007. The single agency is headed by a Chief Executive Officer. The Department has six divisions: Public Health, Behavioral Health, Children and Family Services, Developmental Disabilities, Medicaid and Long Term Care, and Veterans Homes. Title V/MCH functions are located in the Division of Public Health. Title V/CSHCN functions are within the Division of Medicaid and Long Term Care.

The Division of Public Health, is administered by Joanne Schaefer, MD, Chief Medical Officer and Division Director. Division functions and activities include environmental health, epidemiology, communicable disease programs, vital records, health data, facility and professional credentialing, community health planning and protection, health promotion, and public health services for various populations, including MCH.

The Lifespan Health Services Unit, Division of Public Health, provides the principle over sight for administration of the Title V/MCH Block Grant. Planning and Support staff manages the block grant and reports to the Administrator for the Unit who is also the Title V/MCH Director. Planning and Support includes the Federal Aid Administrator and an Administrative Assistant, for a total of 2.0 FTE. Planning and Support is responsible for organizing and leading the development of the annual plan and report, administers sub-grants to communities, monitors allocations to other NDHHS units and programs, and coordinates Title V funded activities with other public health programs within the Unit and agency.

The Lifespan Health Services Unit was formed in 2007, with the merging of the Office of Family Health with the Office of Women's Health. Other programs and activities within Lifespan Health Services include: Commodity Supplemental Food Program; WIC; Immunizations; Newborn Screening and Genetics (including Newborn Hearing Screening); Perinatal, Child and Adolescent Health (including school health and Early
Childhood Comprehensive Systems); Reproductive Health; MCH Epidemiology (including PRAMS, Child Death Review, and SSDI-supported activities), Breast and Cervical Cancer Screening, Colon Cancer Screening, and women's and men's health initiatives, including logistical support for the Women's Health Advisory Council.

Special Services for Children and Adults are administered within the State and Grant Funded Programs Unit in the Division of Medicaid and Long Term Care. The Unit houses the following programs: Medically Handicapped Children's Program (MHCP), Social Services Block Grant for the Aged and Disabled (Title XX), Disabled Persons and Family Support, SSI Disabled Children's Program, Genetically Handicapped Persons Program, and Early Intervention and Medicaid in Public Schools Programs. This Unit coordinates with other Units within Medicaid that house the Medicaid State Plan and Home and Community Based Waiver Services for children with special health care needs. The Early Intervention Waiver ended and EI Waiver clients are
now being served by the Home and Community Based Waiver program.

Vivianne Chaumont, the Director of Medicaid and Long-Term Care, administers the
following program areas: Medicaid Services, both State Plan and HCBS Waiver Services for all eligible populations; State Unit on Aging, and the State and Grant Funded Programs Unit which manages CSHCN programs listed in the above paragraph. Ms. Chaumont is the co-director for Part C of the Individuals with Disabilities Education Act and the Administrator of the Nebraska Part C/Early Intervention Program/Early Development Network. Early Intervention is co-administered with the Nebraska Department of Education.

Title V -- both MCH and CSHCN -- maintain very collaborative relationship
with the Medicaid program, Vital Records, and Health Statistics, all of which are located in the Department of Health and Human Services. In addition, Title V works with a number of programs throughout DHHS including: child care, juvenile services, mental
health and substance abuse, developmental disabilities, health disparities/health equity, health promotion and disease prevention, communicable diseases, dental health and rural health. Of the areas outside of Lifespan Health Services and Long Term Care Programs Section, only health disparities/health equity, data management, and dental health receive federal Title V funds. An organizational chart displaying the agencies and units is found as an attachment. Department programs funded by the Federal-State Block Grant Partnership budget are described in the previous section. See Section B Agency Capacity for details of funding for community-based and Tribal programs for the 3-year period that began October 1, 2008.

An attachment is included in this section.

D. Other MCH Capacity

As described earlier, Planning and Support within Lifespan Health Services has
primary responsibility for the ongoing administration of the Title V/MCH Block grant. Programmatic activities are carried out by various staff within the Lifespan Health Services. The Perinatal, Child and Adolescent Health is responsible for school health, adolescent health, child health, Healthy Mothers, Healthy Babies toll-free line,
perinatal issues such as perinatal depression and the First Time Motherhood/New Parents Initiative grant, and the Early Childhood Comprehensive Systems (ECCS) grant. This unit is staffed by 5.0 full time staff.

MCH Epidemiology was created in FFY 2004, and includes PRAMS, Child Death Review, and

SSDI activities. It is staffed by 3.5 FTE and a 0.75 contract employee.

The Newborn Screening and Genetics Program staff is responsible for the oversight of Nebraska's newborn metabolic screening activities, genetics planning and development, and newborn hearing screening. It is staffed by 5.0 full-time employees and 1.5 temporary employees.

In addition to administering the Title X grant, the Reproductive Health Program carries out a wide range of activities related to women's and adolescent health and is staffed by 3.4 full-time employees, and a nurse practitioner consultant and a medical advisor under contract.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides supplemental food, nutrition and health education, and related services through 14 local agencies across the state. The program currently serves over 45,000 participants each month. WIC has provided leadership in MCH nutrition activities, including breastfeeding promotion and support. The State WIC Director is Nebraska's representative to the Association of State and Territorial Public Health Nutrition Directors (ASTPHN). The program is staffed by 10 full-time FTEs, with an additional information technology FTE under contract.

The Commodity Supplemental Food Program serves 14,000 individuals each month, the majority being seniors. This program is staffed by 1 full time FTE.

Also administered within the Lifespan Health Services, the Immunization Program manages CDC 317 and Vaccine for Children funds, and oversees public immunization clinics and the registry supporting these clinics. The program is staffed by 9 full time FTEs and 2 contract employees.

The Office of Women's and Men's Health within the Lifespan Health Services Unit has 23 FTEs. Though its major programs focus on older adults, it also administers State General Funds that support cervical cancer screening for women of reproductive age. The Women's Health Council, which is supported by the Office, addresses a wide range of issues for women. Currently, the Council has an active workgroup examining access issues for women experiencing pregnancy related depression. The Council has also partnered with other organizations to launch an initiative to address health disparities.

The Patient Protection and Affordable Care Act offers much potential for additional MCH capacity, including that home visiting, abstinence education, personal responsibility education, and the pregnancy assistance fund. The Division of Public Health is actively considering the FOA's for these funding opportunities as they are released.

The Lifespan Health Services Administrator participates in a wide range of collaborative activities and initiatives described elsewhere. She is supported by a 1.0 Administrative Assistant and 0.2 FTE staff assistant. Paula Eurek, BS, Title V/MCH Director, has been an employee of Nebraska Health and Human Services since 1983. Her maternal and child health experience includes two years of community-level experience as a WIC nutritionist and over 10 years as a state-level WIC nutritionist and administrator. Ms. Eurek assumed the roles of Administrator for what was the Family Health Services Section and Title V/MCH Director in December, 1995. She had prior experience as the interim MCH Division administrator in 1988-1989.

In addition to administering MHCP, the State and Grant Funded Programs Unit in the Division of Medicaid and Long Term Care is responsible for a number of CSHCN services and activities. It partially funds the Answers4Families website which includes comprehensive information for families of children with special needs, school nurses, foster and adoptive families, and families, agencies and others concerned with children's mental health. The website hosts discussion LISTSERV (discussion groups for these populations) as well as information and Internet LISTSERV for other populations with special needs. Nebraska Resource Referral System (NRRS), which includes over 8,000 social services type resources including child care, respite coordinator information, medical/health and public health information, food pantries, is accessible

through this web portal. Addresses: http://www.answers4families.org and http://www.answers4families.org/nrrs/. The MHCP clinic list and addresses of local workers are available on Answers4Families. Address: http://www.hhs.state.ne.us/hcs/programs/MHCP.htm. Answers4Families site also includes a list of clinic staff and a short bio of background information to provide families looking at clinic services, information on the medical providers their child would receive services from.

The Home and Community based Services for Aged and Physically Disabled is a Co-Lead for Part C of the Individuals with Disabilities Education Act along with the Nebraska Department of Education, Special Populations. Consequently, the Family Partner full time position represents families for both the Early Development Network programs and the CSHCN programs. The Family Partner attends CSHCN training for CSHCN staff, national MCH/CSHCN meetings and is a member of advisory groups to the CSHCN Program. The CSHCN Nurse Consultant staff member has been a family member of a CSHCN in the past but this currently is not the situation.

Development Tips is tracking Infant Progress statewide in Nebraska and started in 2000. The program provides specialized development follow-up for babies who have been in the Neonatal Intensive Care Unit. The Development TIPS program has two main goals: to provide a standard system of developmental follow-up for all infants who have had an NICU experience in Nebraska, and to gather information about how babies who have been in the NICU grow and develop, so we can learn how to better meet their unique needs in the future. EDN Services Coordinators are partners with 10 departments/programs to direct referrals to the appropriate service. In 2007, two additional partners where added to the list of partners (Bryan LGH and Alegant Lakeside in Omaha). Developmental TIPS also plans to begin data collection for the next three years on children that were part of the program that are now entering first grade.

Susan Buettner, JD, Title V/CSHCN Director, has been an employee of the State of Nebraska since 2008. She is currently the Administrator of Long-Term Care Programs in the Medicaid and Long-Term Care Division of the Nebraska Department of Health and Human Services; areas of responsibility include Medicaid State Plan, and Home and Community --Based Services for long term and chronic care, State Unit on Aging and the State and Grant Funded Programs Unit programs. Previous work assignments have included: Special Appointed Attorney General for the State of Nebraska, Department of Health and Human Services; Deputy County Attorney for Lancaster County; and Adjunct College Instructor.

E. State Agency Coordination

Nebraska DHHS is part of a coordinated funding committee that encompasses Vocational Rehabilitation, MHCP, the Developmental Disabilities Council, League of Human Dignity, Aged and Disabled Medicaid Waiver, Easter Seals Society, United Cerebral Palsy, the Disabled Persons and Family Support Program, and other private non-profit programs to assure that individuals receive services for which they are eligible. This committee of providers and advocates has met to discuss individual care plans and find solutions which make the most efficient use of program resources for the past 26 years.
The Coordinated Family Committee continues to meet on a quarterly basis to review and discuss funding of individual cases. The Coordinated Family Committee continues to meet on a quarterly basis to review and discuss funding needs of individual cases. Statewide service and support presentations are completed by outside entities to expand the committee's knowledge of additional resources that offer funding assistance.

Child Abuse Prevention Treatment Act (CAPTA) is improving Nebraska achievement under the federal mandate. EDN has collaborated with Juvenile Court Judges, child development experts, and Protection and Safety CPS staff to provide statewide training to all professionals and families involved in child abuse and neglect court system. EDN has provided several trainings to assist all

entities to understand the law and to work together to integrate the system. Most recently, the collaboration has been expanded to include; children & family mental health providers, Family Court Judges, family and juvenile court attorneys. Since 2005, there have been trainings on the local level on CAPTA to CPS and EDN workers. These trainings are now on-going to work on issues and problems surrounding implementation of the mandate.

As part of the Nebraska Newborn Hearing Screening Program's Early Hearing Detection & Intervention (EHDI) State Plan one of the System Goals/Activities is: All infants with a confirmed hearing loss will begin receiving early intervention services prior to six months of age. Under Program Objective 3.1, Health care providers and audiologists will refer all newborns and infants with suspected or confirmed hearing loss to the Early Development Network (EDN) for eligibility determination.

From this, EHDI and EDN developed Recommended Practices regarding Initial Point of Entry for Parents of Infants/toddlers identified with permanent hearing loss and was implemented in 2009. The desired outcomes includes: Families of newborns/infants identified with a permanent hearing loss will be able to access timely and appropriate early intervention services through a recognized point of entry that is knowledgeable about hearing loss, the effects on young children, and available resources (certified teachers of the deaf).

EDN Services Coordinators and Audiologists are continuously trained on these collaborative practices and processes relating to EDN referrals and early intervention services. EHDI and EDN State program managers track related referral, intervention and outcome data on infants identified with a hearing loss between these two programs/systems. Since implementation of this collaborative process, EDN/Part C has served 100% of all children identified with a hearing loss by the EHDI program.

The Disabilities Determination Unit (DDU) for Social Security and SSI is located in the Nebraska Department of Education. The DDU sends notification to MHCP of children determined eligible for SSI, at which time MHCP sends a notice to the family describing possible services they may receive and how to apply. This relationship ensures that families receiving SSI for their children are notified of their potential eligibility for services. The Disability Determination Unit of Social Security provides a continual stream of referrals to the MHCP. As the result of the notification of SSI eligibility, MHCP workers have been able to provide immediate notification to families regarding the availability of services through SSI-DCP.

In regards to coordination with EPSDT, referral assistance must be provided for treatment not covered by Nebraska Medicaid, (i.e., those services not covered under 1905(a) of the Social Security Act) but found to be needed as a result of conditions disclosed during the screening exam. This includes giving the family or client the names, addresses, and the telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family. Workers may contact the EPSDT coordinator in the Medical Services Division for referral resources. The program workers may also utilize the Nebraska Resource Referral System to attempt to provide referral assistance.

With the administration of Nebraska's Title V/MCH Block Grant located within the Lifespan Health Services Unit, abundant opportunities exist to coordinate Block Grant investments with a wide range of MCH programs and activities funded through other sources, including WIC, CSFP, Immunizations, and Reproductive Health. Then, with the Lifespan Health Services being in the same section of the Division of Public Health with the Offices of Rural Health, Health Disparities and Health Equity, Community Health Planning and Protection, and Health Promotion, another and even more significant level of collaboration opportunities exist. References to these collaborative efforts are found throughout this application.

Within the larger Department of Health and Human Services, Lifespan Health Services has ongoing and active partnerships with Child Care Subsidy and Child Welfare within the Division of

Children and Family Services, and Child Care Licensing within the Division of Public Health. It has expanded its collaboration with Behavioral Health, in conjunction with the Mental Health Component of the ECCS grant, the SAMHSA SIG project, and the perinatal depression grant.

The Nebraska Department of Education (NDE) is an active partner with Lifespan Health Services in carrying out early childhood programs and initiatives, including ECCS. The Title V/MCH Director has been reciprocally active in the NDE's Early Childhood Policy Initiative, the development of Early Learning Guidelines, and administration of the statutorily required READY Act (early learning materials for all Nebraska newborns and their families).

Nebraska Title V has a long-standing working relationship with the state's urban health departments. Both the Douglas County Health Department and the Lincoln/Lancaster County Health Department currently receive Title V funds for specific activities, but each have been partners in a wide range of initiatives. For instance, representatives of the Douglas County Health Department actively participated in the recently completed needs assessment and were active participants in strategy development work groups. A staff person with the Lincoln/Lancaster County Health Department (LLCHD) also participated in the needs assessment process and has been active work groups. Both urban health departments had representatives participated in a Infant Mortality Disparity work group. This work group will be described in greater detail later in this report/application. In addition, the Douglas County Health Department, through a contract, is developing specific capacity to further develop and promote preconception health interventions in the Omaha area.

Nebraska Title V also works with local health departments in more rural areas of the state and with other community health agencies, both as a funder and a collaborator. These local health departments and community health agencies have been key stakeholders participating in a number of projects, including the needs assessment and strategy development work groups.

Nebraska's federally qualified health centers continue to be key partners in serving the MCH population. The Charles Drew Health Center, through its Healthy Start program, provides enabling services to the perinatal population of northeast Omaha. Lifespan Health Services works whenever possible to connect state level activities with Omaha Healthy Start. Staff with Omaha Health Start, Charles Drew Health Center participated in the Infant Mortality Disparity work group this past year.

Local health departments, federally qualified health centers, and applicable Title V supported community projects are key partners in assuring that pregnant women access prenatal care and help identify pregnant women and children eligible for Medicaid services. In turn, Medicaid presumptive eligibility for pregnant women continues to be determined by many of these providers.

Nebraska Title V continues its working relationship with the Primary Care Office by sharing data and information. The Primary Care Office was of particular assistance in providing health professional data for the comprehensive needs assessment.

Nebraska Title V works closely with a number of programs and departments within the University of Nebraska Medical Center (UNMC). The Munroe-Meyer Institute is a close collaborator on a number of CSHCN projects. Many other working relationships exist with various faculty and staff throughout Nebraska's university systems, including development and support of internet-based services for families of CSHCN and for school nurses.

The UNMC College of Public Health was formed in 2007. This college, along with the Great Plains Public Health Leadership Institute, provide opportunities for collaborations around staff development and building public health capacity. Of particular note are plans to develop a MCH emphasis at the CoPH. In addition, CityMatCH, with its administrative home in Nebraska and with partial support from UNMC, has been a valuable partner in a number of MCH initiatives.

Lifespan Health Services continues to develop and sustain a wide range of partnerships. During FY 2009, the Adolescent Health Program applied for and received a mini-grant from AMCHP to support systems planning for adolescent health. Using the ECCS framework as a model, the Adolescent Health Coordinator has assembled a wider range of partners to begin developing a framework specific for adolescent health and well being. Partners include local health departments, family representatives, community advocates, school systems, state department of education, child welfare, Medicaid managed care for mental health, and others. This collaborative project will continue into FY 2010 with the support of Title V funds.

An important partner for both Title V MCH and CSHCN is PTI Nebraska. PTI Nebraska is a statewide resource for families of children with disabilities and special health care needs. PTI Nebraska's staff are parent/professionals and are available to talk to parents and professionals about special education, other services and disability specific information. PTI Nebraska conducts relevant, no cost workshops statewide and provides printed and electronic resources. PTI Nebraska encourages and supports parents in leadership roles. Its Mission is to provide training, information and support to Nebraska parents and others who have an interest in children from birth through twenty-six and who receive or who might need special education or related services and to enable parents to have the capacity to improve educational outcomes for all children. PTI and particularly its Family to Family Program has collaborated with Nebraska Title V on activities ranging from the needs assessment, to oral health access, and to medical home initiatives.

The Medically Handicapped Children's Program (MHCP) is working in collaboration with Boys Town Research Institute for Children's Health Improvement on a medical home model which includes 10 medical practices from across Nebraska. The activities of this project support transitioning the 10 practices to medical homes providers for the children and youth with special health care needs patients they are serving. This collaboration provides different activities to improve the primary health care delivery system for CSHCN and has an emphasis on care coordination.

The MHCP Program continues to work with the Answers4Families website to provide an overview of our clinic services and their staff. The collaboration also provides a resources network for families to access local resource information to help meet their identified needs.

With two new Medicaid Manged Care Plans going into effect August 1, 2010, opportunities will be available for coordination on performance improvement projects impacting a 10 county area. This area includes the bulk of Nebraska's Medicaid eligible MCH and CSHCN population. The 2 health plans (Coventry and Share Advantage) will begin reporting on a number of HEDIS performance measures, with these of particular relevance to MCH and CSH: Comprehensive Diabetes Care; Chlamydia Screening in Women; Cervical Cancer Screening; Use of Appropriate Medications for People With Asthma; Medical Assistance With Smoking Cessation; Prenatal and Postpartum Care; Frequency of Ongoing Prenatal Care; Well Child Visits in the First 15 Months of Life; Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life; Adolescent Well-Care Visits; Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC); Lead Screening in Children; Childhood Immunization Status Combo 2 and Combo 3; Childhood Immunization Status Combo 3; Race/Ethnicity Diversity of Membership; and EPSDT Screening Participation Rate.

The managed care program for physical health is now in the following counties: Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington. Also, for case management, the clients that must be offered case management services. Each health plan must conduct a Health Risk Assessment and offer Case Management/Disease Management activities to the following groups of clients at a minimum: Clients falling under the Medicaid eligibility category of the Aged, Blind and Disabled, i.e., AABD; Special Needs clients; Children who are in Foster Care Placement; Clients with chronic and/or special health needs (i.e. diabetes, asthma, hypertension, and obesity at a minimum); Clients at risk for poor health outcomes;

Children with positive results from lead testing; Clients discharging from the hospital; Clients in Lock-In status; Clients with multiple missed medical appointments; Clients with screening results indicating referral treatment without follow up; Clients requesting case management activities; and Clients whose PCP has made a referral for case management activities.

F. Health Systems Capacity Indicators

Introduction

Brief narratives are provided for each of the indicators. Details of activities are found elsewhere in this application.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	21.8	15.2	17.3	12.2	
Numerator	219	194	224	164	
Denominator	100490	127665	129796	134717	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Hospital Discharge Data will be available in October 2010.

Notes - 2008

2008 HDD data is released in October of 2009.

Notes - 2007

2007 HDD data is released in October of 2008.

Narrative:

The Nebraska Department of Health and Human Services no longer has an asthma program. The 3-year CDC grant expired at the end of FFY 2006.

Through the School and Child Health Program, in collaboration with the Department of Education and a non-profit organization called Attack on Asthma Nebraska (AOAN), priorities addressed in the past year have included: training of school personnel to recognize and respond to asthma emergencies; providing schools with resources to improve "asthma-friendly" school environments; and continuing education and consultation for school nurses in developing individualized healthcare plans (IHPs) with parent and medical provider collaboration for students with asthma.

In 2009, the state school nurse consultant delivered four regional training events for professional school nurses, and addressed asthma in back-to-back sessions on responding to emergencies at school, and on developing individualized healthcare plans. In addition, the largest school district in Nebraska, Omaha Public Schools, requested and received additional training events for all

OPS school nurses on IHPs (2 events) and on documentation standards for emergency planning and response (2 hours in a day long emergency preparedness event), with the focus on liability and standard of practice issues when written plans are not in place for the child at school known to have asthma.

Annually Attack on Asthma Nebraska collaborates with the planning committee for the Annual School Health Conference to both exhibit materials and deliver continuing education on responding to life-threatening breathing emergencies due to asthma and anaphylaxis.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	98.7	98.8	98.3	98.4	97.4
Numerator	12575	12933	13277	13402	13284
Denominator	12743	13094	13510	13625	13641
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
Nebraska Medicaid provides local Public Health Nurse contracts to do outreach to families that otherwise may not receive information regarding the EPSDT program. This outreach is to assist families access and utilize the services provided. Continued outreach may help families understand the services offered as well as prepare for transition beyond the limits of the program.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	86.6	87.7	84.7	85.9	64.0
Numerator	862	876	866	972	438
Denominator	995	999	1023	1131	684
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Staff recognizes issue and looking into the significatn drop.

Notes - 2007
Medicaid was asked to verify and interrupt the drop. Staff stated 2003-2005 should have been reported 82.9, 86.6, 86.6%.

Narrative:
Nebraska Medicaid has had an increase in enrollment while the enrollment rate for the Nebraska CHIP program has decreased. The changes in the economy of Nebraska may play a role in this change in enrollment. Several programs or strategies may increase the number of children receiving screening which include expanding the Managed Care into ten counties surrounding the two largest populous cities of the state. As well, Nebraska Medicaid provides local Public Health Nurse contracts to do outreach to families that otherwise may not receive information regarding the EPSDT program. This outreach is to assist families access and utilize the services provided. Continued outreach may help families understand the services offered as well as prepare for transition beyond the limits of the program.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	63.0	66.4	72.5	72.5	74.5
Numerator	16429	17712	18916	19027	19403
Denominator	26085	26659	26096	26244	26052
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births). Over 2% of the data for this PM is missing/unknown.

Narrative:
The content, quality, and frequency of prenatal care visits have not been a recent focus for Nebraska Title V. With access to and quality of perinatal health care, including prenatal care, as a recently identified priority, more in depth analysis of the issues and subsequent strategy development will need to be carried out in the future. An infrastructure building contract with the Douglas County Health Department has included some prenatal care quality indicators, and the data collected through that work will be useful in going forward.

The new Medicaid Managed Care contracts and associated performance improvement projects will provide additional opportunities to impact this indicator.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	96.8	96.9	96.9	97.0	97.1
Numerator	153502	154580	155320	159496	166459
Denominator	158500	159580	160320	164496	171459
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
The indicator shows that there is a high utilization of services offered by Nebraska Medicaid. The indicator also shows that there is appropriate and adequate access to services. Additional strategies to improve access and utilization includes the expansion of Managed Care into ten counties surrounding the two largest populous cities in Nebraska. The Managed Care Organizations have marketed families by a large media campaign that included television, radio and print ads.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	61.3	61.7	63.6	64.2	65.6
Numerator	18869	19384	20265	20948	22709
Denominator	30763	31427	31870	32633	34629
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
Access to dental services for Medicaid eligible children has been a significant issue for Nebraska for a number of years. Two factors are in play, the first being insufficient numbers of dental providers, particularly in rural counties. The second is the number of dentists accepting Medicaid patients. In the spring of 2009 Nebraska Medicaid added primary care providers as a group that could bill for fluoride varnish treatments. Also, utilizing the HRSA oral health grant as an additional resource, and the hiring for the position of Director for the Office of Oral Health and Dentistry after a 3 year vacancy have set in motion a number of activities to address oral health

access issues for children. Additionally, Nebraska Medicaid is participating in the Head Start dental medical home project that will commence in the next year.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	32.6	36.5	37.0	35.1	35.4
Numerator	967	1101	1375	1149	1234
Denominator	2964	3016	3715	3278	3482
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Num = NE CONNECT number of children 15 and younger receiving services (MHCP and/or SSI-DCP)FY 2007.

DEN = Table 7 SS1 payments Dec, 2007 via Healthy and Ready to Work

Narrative:
The Nebraska CSHCN (MHCP) program does not provide rehabilitative services. So this indicator measures those who received any services in a given year.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	matching data files	8.5	5.5	7

Narrative:
Nebraska Medicaid pays for prenatal care for women who seek services, including presumptive eligibility for women who seek care but have not been determined to be eligible for Medicaid. Medicaid Managed Care, now expanded to 10 counties, will provide additional opportunities to address quality of care through performance improvement initiatives.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-**	**ALL**

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Infant deaths per 1,000 live births	2008	matching data files	5.2	3.8	4.5

Notes - 2011
This match is only for infants who passed in 2008 which excludeds the infants who were born in 2007 but passed in 2008. So, the "all" catagory is smaller than the true rate.

Narrative:
These rates represent a shift from previous years, and will require additional analysis to understand this reversal. Small numbers may be an issue.

Since so many factors impact IMRs, access to and content Medicaid services to both prenant women and infants will be monitored. And within a lifecourse health framework, there are social and ecological factors at play as well.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	matching data files	73.7	90.7	82.8

Notes - 2011
This data is based on linked files, of which 95% of Medicaid births were matched with a birth certificate number, becasue not all Medicaid births were matched the data reported in the all category will not be the same as reported in HSCI 05C.

Narrative:
Nebraska Medicaid pays for prenatal care for women who seek services, including presumptive eligibility for women who seek care but have not been determined to be eligible for Medicaid.

Early access to prenatal care is complex at the community level. Initiatives to promote preconception health, including identification medical homes for women, will be pursued.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-**	**ALL**

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	matching data files	58.8	72.3	65.8

Notes - 2011
This data is based on linked files, of which 95% of Medicaid births were matched with a birth certificate number, becasue not all Medicaid births were matched the data reported in the all category will not be the same as reported in HSCI 05D.

Narrative:
Nebraska Medicaid pays for prenatal care for women who seek services, including presumptive eligibility for women who seek care but have not been determined to be eligible for Medicaid. Again, performance improvement projects through Medicaid Managed Care will provide an opportunity to assess and address factors related to the quality of care.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Narrative:
Nebraska CHIP provides eligibility for children at 200% of the FPL. There was an expectation by Nebraska Medicaid that there would be an increased number of children added to the CHIP program in 2009, however, the numbers actually decreased and the number of families eligible for the Medicaid program increased.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2009	 133 100

INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2009	200

Narrative:
Eligibility for Medicaid for children ages birth to 1 is up to 150% of the FPL, for ages 1-5, 133% of the FPL, and 6-18, 100% of the FPL. Eligibility for CHIP is up to 200% of the FPL.

Nebraska Medicaid is also participating in letters of support to state based grantees for CHIP outreach programs to find and enroll children into either the Medicaid or CHIP program.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2009	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	185

Narrative:
The percentage is 185% of the FPL for women to qualify for Medicaid. CHIP doesn't cover women currently, including pregnant women.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
	2	Yes

Annual linkage of birth certificates and WIC eligibility files		
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
Nebraska continues to improve and refine the data linkage capacity. While Lifespan Health Services has the ability to obtain data in a timely manner it has limited manpower to optimally utilize the data.

Nebraska has been fortunate to receive funding from CDC for the Early Hearing Detection and Intervention Tracking, Surveillance, and Integration project which furthers SSDI efforts by linking the birth, newborn hearing, and Connect (CSCHN)databases. The linkage of the birth file with the WIC eligibility file has been the least successful on an annual basis and capacity improvements will be a focus of data linking projects of SSDI. As described in detail in HSCI #01 the Hospital Discharge Database has experienced reporting issues. Nebraska PRAMS has recently a five-year cooperative agreement carrying its activities into 2011. Nebraska has implemented the Nebraska State Immunization Information System
The NESIIS is linked with Vital Records system, and work is underway to further link with other electronic reporting systems. Other changes in the upcoming year is the development a new computer system for WIC. There have been set backs in the development of a new Medicaid data system which are being addressed.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	2	Yes
Youth Tobacco Survey	3	Yes
Nebraska Risk and Protective Factor Student Survey	3	Yes

Notes - 2011

Narrative:
The Nebraska YRBS is conducted biannually. However, because the largest school district (Omaha Public Schools) does not participate the results are not generalizable to the entire state. Ongoing efforts of numerous stakeholders have been attempting to address this issue for many years.

The Pediatric Nutrition Surveillance System is WIC data aggregated by CDC. Nebraska uses this data on a limited basis as it is restricted to a sub-set of the population. Perhaps the best source of information about the tobacco use by youth is the Nebraska Risk and Protective Factor Student Survey (NRPFSS) which was administered in the fall of 2003 and 2005 to Nebraska students in grades 6, 8, 10, and 12. The survey is designed to assess adolescent substance use, anti-social behavior, and the risk and protective factors that predict adolescent problem behaviors. The Nebraska survey is adapted from a national, scientifically validated survey and contains information on the risk and protective factors that are: 1) locally actionable, 2) not obtainable through any other source, and 3) more highly correlated with substance abuse. One of the goals of the survey was to provide schools and communities with local level data to assist in planning comprehensive, evidence-based prevention initiatives.

DHHS has collaborated with the Nebraska Department of Education to convene the school-based student health survey initiative. This initiative brought together educators, researchers, public health, and data users to discuss the three surveys. The discussion was about methodology, response rates/participation, and decreased school time. A set of recommendations has been made and are being vetted to funders and administrators. The goal is to implement all three surveys successfully while minimizing school interruption.

IV. Priorities, Performance and Program Activities

A. Background and Overview

This application for FFY 2011 marks the beginning of a new 5-year planning period. The Needs Assessment completed in 2010 establishes a new list of priorities. Though some of the priority issues had been identified in previous assessments, the new list reflects a subtle but distinct shift towards socio-ecological determinants of health and thus a greater consideration of system level strategies.

Yet at the same time, the impact of a national recession has been felt in Nebraska. Needs of children and families have increased while at the same time public resources are diminishing. The focus of the Nebraska Legislature, as it has been in many other states, has been to address revenue shortfalls. Thus there is a natural tension between the need to maintain basic services with our existing resources while at the same time attempting to move towards new models and interventions.

The Affordable Care Act (ACA) is proving to be a resource for some MCH interventions, notably home visitation, teen pregnancy prevention, and supports for pregnant and parenting teens and women. Such funds, though, are categorical and do not alleviate the need to continue to invest Title V and other funds in ongoing programs and to try to meet the increasing demands placed on them.

For instance, between 2008 and 2009, The Medically Handicapped Children's Program has increased its number of pending and open applications by 24%. The MHCP Program had 316 pending and open cases in 2008 compared to 397 open and pending cases ending FY 2009 yet the available funding has stayed the same. The program saw a 211% increase in pending and open applications for children with a diagnosis of diabetes. MHCP continues to balance between the rising need and the stagnant funding to meet the increasingly complex medical needs of CSHCN. The MHCP program continues to fill the gap in health services and supports by providing necessary medical care and supportive services to families across Nebraska with children with complex medical needs. Out of the 397 pending and open applications for FY 2009, 14.6% did not have health coverage.

Title V funds continue to be a primary or significant source of support for many other components of Nebraska's public health and MCH infrastructure, such as New Born Screening, Birth Defects Registry, Child Death Review Team, and Oral Health. In recent years, the proportion of Title V funds needed to maintain this infrastructure has steadily increased to over two thirds of the Block Grant. The ability to address new priorities and move to new public health models will require special attention to incorporating new strategies into old programs, developing new and expanded partnerships, and diligence in identifying and seeking new grant sources.

B. State Priorities

Nebraska completed its most recent comprehensive needs assessment in 2010. Ten priority needs were identified. Below is a description of each priority need, NE's capacity and resource capability to address each, and the relative National and State performance measures. It must be noted that community-based projects addressing priority needs will NOT be known until planning for state-level strategies is conducted in FFY 2012.

1. Increase the prevalence of the MCH/CSHCN population who are physically active, eating healthy, and are at a healthy weight.

This need was identified in the 2005 and has been retained. Nebraska's capacity assessment

committee determined the capacity to address this need as high due the large amount of resources that have been made available to address this issue, the broad based networks/collaborative(s) that are engaged, and the level of knowledge/analysis of the priority. Nebraska will retain State Performance Measure (SPM) # 1 and will use National Performance Measure (NPM) #14 to monitor progress.

SPM # 1: Percent of women (18-44) with a healthy weight.

NPM # 14: Percentage of children, age 2-5 years, receiving WIC services with a BMI at or above 85th percentile.

2. Improve the reproductive health of youth and women by decreasing the rates of STD's and unintended pregnancies.

This is a new priority. The priority is based on the increasing trend in STD's for youth and women as well as the persistent rate of unintended pregnancy. These data speak to the broader context and need to improve the reproductive health of youth/women. The capacity level for this priority is low due to modest funding levels and need for more dedicated resources, the lack of formal networks/coalition(s) especially state-wide, and lack of consensus among the public regarding teen pregnancy and sexual activity as a problem. Nebraska will use the following measures to track progress:

Health Status Indicator # 5A and 5B: The rate per 1,000 women age a) 15 -19 and b) 20-44 with a reported case of chlamydia.

NEW SPM : The percentage of live births that were intended at the time of Conception.

3. Reduce the impact of poverty on infants/children including food insecurity.

This is a new priority identified by the comparison of poverty rates among Nebraska's infants and children with the national rates as well as the increasing rates of food insecurity. The capacity level assigned is moderate due to the relatively high number of programs and resources targeted at poverty, but the lack of public health participation in the networks/coalitions and the lack of expertise in addressing the issue. Nebraska will use the following measure to track progress:

NEW SPM : The percent of children living in poverty who have health insurance.

4. Reduce the health disparities gap in infant health status and outcomes.

This new priority incorporates two former priorities: 1) Reduce the rates of infant mortality, especially racial/ethnic disparities, and 2) Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy. The Needs Assessment Committee determined that reducing disparities in infant health would reduce rates of infant mortality, preterm and low birth weight births, as well as impact many other indicators across the remaining life course. The capacity level assigned is moderate because while there are programs dedicated to improving disparities in infant outcomes they are spotty, need more resources and are not adequately networked together. While data is available there is need for more evidence-based interventions. Nebraska will use the following measure to track progress:

Outcome Measure # 2: The ratio of the African American infant mortality rate to the Caucasian rate.

NEW SPM : The ratio of the African American premature birth rate to the Caucasian rate.

5. Increase access to oral health care for children and CSHCN.

This is a new priority identified by the availability of more data from the National Survey on Children's Health and the low rates of access to care among Medicaid/EPSDT eligible children. The capacity level assigned is moderate because there is knowledge on how to address the problem and the amount of effort to address the problem is high, however surveillance (open mouth survey) needs to be updated and the provider shortages and barriers to accessing care particularly for Medicaid enrolled children are a significant. Nebraska will use the following measure to track progress:

NPM # 9: The percent of children who have received a protective sealant on at least one permanent molar tooth

HSCI #7B: The percent of EPSDT eligible children Medicaid aged 6 through 9 years who have received any dental services during the year.

NEW SPM : The percent of young children (1-5) who have excellent/very good dental health.

6. Reduce the rates of abuse and neglect of infants and CSHCN.

This need was identified in 2005 and has been retained and narrowed to the most vulnerable subpopulations, infants and CSHCN. The capacity level assigned however is low because Nebraska still lacks a comprehensive primary prevention system, and does not have adequate maltreatment surveillance. The current system requires quality improvements in data collection for CSHCN, and while the working relationships between child welfare and public health are adequate they can be enhanced. Nebraska will use the following measure to track progress:

NEW SPM: The rate per 1,000 infants of substantiated reports child abuse and neglect.

7. Reduce alcohol use and binge drinking among youth.

This need was identified in 2005 and has been retained. The capacity level for this priority is high due to years of funding for infrastructure and local collaborative(s) who are currently implementing/evaluating evidence based interventions. Nebraska will use the following measure to track progress:

SPM # 4 Percent of teens who report use of alcohol in the past 30 days.

8. Increase quality of and access to perinatal health services, including pre/interconception health care, prenatal care, labor and delivery services, and postpartum care.

This is a new priority. The capacity level assigned is moderate due to the changing environment surrounding funding and other resources, as well as a lack of gap filling services. Nebraska will use the following measures to track progress:

NPM # 18: Percentage of infants born to women receiving prenatal care beginning in the first trimester.

HSCI # 4: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

9. Increase the prevalence of infants who breastfeed exclusively through six months of age.

This is a new priority identified by the availability of more data from multiple sources. The capacity level assigned is high due to the strong network of advocates in the Nebraska Breastfeeding

Coalition, the knowledge of how to address the priority, and the federal legislation addressing workplace policies. Nebraska will use the following measure to track progress:

NPM # 11: The percent of mothers who breastfeed their infants at 6 months of age.

10. Increase access to Medical Homes for CSHCN particularly for those with functional limitations.

This is a new priority identified by the availability of more data from the National Survey on Children's Health and the National Survey of Children with Special Health Care Needs. The capacity level assigned is moderate due to the strength of partners who are addressing the need and the knowledge on how to address the problem. But the efforts are fragmented and need systemic implementation. Nebraska will use the following measure to track progress:

NPM # 3: The percent of CSHCN 0-18 who receive coordinated, ongoing, comprehensive care within a medical home.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	98.7	98.8	100.0	100.0	100.0
Numerator	153	167	185	545	600
Denominator	155	169	185	545	600
Data Source				Program Data	Program Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
123 babies had a presumptive positive and 477 had inconclusive screening result for a disease requiring confirmatory or repeat testing(follow up) .(this number does not include hemoglobinopathy patterns that were indicative of trait/carrier status)

4 out of the 477expired and required no follow up.

Notes - 2008
545 babies had a presumptive positive or inconclusive screening result for a disease requiring confirmatory or repeat testing(follow up) .

(this number does not include hemoglobinopathy patterns that were indicative of trait/carrier status)

23 out of the 545 expired and required no follow up.

a. Last Year's Accomplishments
The Nebraska Newborn Screening & Genetics Program managed mandated screening for 28 diseases (Argininosuccinic Acidemia, Beta-ketothiolase deficiency, Biotinidase Deficiency, Carnitine Uptake Defect, Citrullinemia, Congenital Adrenal Hyperplasia, Congenital Primary Hypothyroidism, Cystic Fibrosis, Galactosemia, Glutaric Acidemia type I, Hemoglobinopathies, Homocystinjura, Isovaleric Acidemia, Long Chain Hydroxyacyl-CoA Dehydrogenase Deficiency, Maple Syrup Urine Disese, Medium Chain Acyl-CoA Dehydrogenase Deficiency, Methylmalonic Accidemia, (MMA-Mutase), Methylmalonic Acidemic (Cbl A, B), Multiple Carboxylase Deficiency, Phenylketonuria, Propionic Acidemia, Tyrosinemia, Trifunctional Protein Deficiency, Very Long-Chain Acyl-CoA Dehydrogenase Deficiency, 3-Hydroxy 3-mthylglutaric aciduria, and 3-Methylcrotonyl-CoA Carboxylase Deficiency) during this reporting period
All newborn specimens from Nebraska newborns were sent to PerkinElmer Genetics Inc. Laboratory. A negotiated rate of $38.50 is charged for testing and the NBS fee. The total charge is billed to the specimen submitters. For each infant screened the laboratory retained $28.50 for shipping, laboratory testing services and reporting, and $10 per infant was returned to the state program to help support the provision of metabolic formula and food, dietitian consultation and part of an FTE for a Pediatric Metabolic Specialist to assist the program with initial follow-up communication with newborns' medical homes.

The contracts to provide metabolic foods and formula and medical/dietary services were supported via Cash funds from revenue generated by the fee, State General funds and the Title V Block grant allocation to the program. In addition, Title V funding helped support a consultant agreement with the Accredited Cystic Fibrosis Center to assist with follow-up and a consultant agreement with a pediatric hematologist.

The numbers screened can only be reported by calendar year. Ninety nine and ¾ per cent (99.75%) of all births in Nebraska received a screen. In 2009 Nebraska had 27,199 births reported (preliminary numbers) to the Newborn Screening Program of which 27,131 were screened. Sixty-seven were not screened as they expired by 48 hours of birth. One was not screened as parents were traveling through the state at the time of birth, and the hospital did not obtain a specimen. There were 99 home births, of which all were screened but two who expired.

Fifty four (54) newborns with disorders were identified and treated early to prevent mental retardation, physical disabilities and disease, and infant death. The following list identifies which conditions and the number of babies who were picked up on the screen and for whom early intervention was initiated:

- 5 babies with partial biotinidase deficiency (treated)
- 1 newborn with congenital adrenal hyperplasia (classical)
- 8 newborns with cystic fibrosis (7 classical, 1 non-classical)
- 15 newborns with congenital primary hypothyroidism (14 with CPH, one with congenital hypothyroidism)
- 1 hypertyrosinemia of infancy (treated)
- 3 newborns with medium chain acyl-coA dehydrogenase deficiency (MCAD)
- 4 Phenylketonuria (3 classical 1 hyperphenylalaninemia)
- 3 Short Chain Acyl-CoA Dehydrogenase Deficiency
- 12 newborns with sickle diseases, (1 sickle cell disease, 5 sickle Hgb C Disease, 3 Sickle Beta Thalassemia, 1 BetaThalassemia Major, 1 Hgb. C Disease, and 1 Hgb. E Disease)
- 1 Very Long Chain Acyl-CoA Dehydrogenase Deficiency
- 1 3-methyl crotonyl carboxylase deficiency (3-MCC)

The program continued to implement in collaboration with the Early Hearing Detection and

Intervention (EHDI) program, the NBSAC & EHDI Advisory Committee's recommendation for incorporating/integrating testing of dried blood spots for genetic causes of hearing loss such as Connexin 26 & 30, CMV, Pendred and mitochondrial causes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screened, referred, tracked & facilitated treatment for 28 required diosrders as per Neb. rev. Stat. 71-519 to 525.			X	
2. Conducted quality assurance activities with hospitals, contracted laboratory, and referral networks.			X	
3. Provided metabolic foods, special formula, and consultation to patients/families through contractual arrangements.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The program continues to screen for 28 required conditions in accordance with the ACMG core panel recommendation. Education, NBS testing, follow-up, referral and treatment and ongoing evaluation and quality assurance activities continue.

The program continued its continuous quality improvement monitoring and submission of individual hospital QA reports (providing statewide averages for comparison), The increasing percent of unsatisfactory specimens continued to be monitored, education sent to hospitals, with special attention to problem facilities. The program continued to press the laboratory to evaluate internal procedures, which resulted in proposed changes that were adopted relative to testing specimens that were heavily applied, double spotted or layered (following a study validating the practice). Nebraska's percent of unsatisfactory specimens improved considerably.

The program continued to implement in collaboration with the Early Hearing Detection & Intervention (EHDI) program, the NBSAC & EHDI Advisory Committee's recommendation for incorporating/integrating testing of dried blood spots for genetic causes of hearing loss such as Connexin 26, CMV, Pendred and mitochondrial.

Staff from the program were actively involved on committees of the Heartland Regional Genetics and Newborn Screening Collaborative. The program manager served on the ACMG's ACT Sheet Committee & the Association of Public Health Laboratory's (APHL) Newborn Screening & Genetics Committee.

c. Plan for the Coming Year

The program and its advisory committee are in the process of evaluating the appropriateness of screening for Severe Combined Immune Deficiency (SCID) as per the endorsement of the Secretary of Health and Human Services. The evaluation includes availability of necessary resources (educational, testing, follow-up, diagnostic, management & treatment) to be able to successfully implement any recommendation to add SCID (and related SCID disorders). This evaluation will continue into the coming year.

The program will continue services as described above, and work to update the emergency preparedness plan, as well as develop a comprehensive management manual for the program. The program recently participated in a Functional Exercise Drill to test its back-up system for testing by providing two days worth of residual dried blood spots for testing to the contracted back-up lab (Iowa Public Health Newborn Screening laboratory).

The program will enhance its work with the Business Analyst for the Early Hearing Detection and Intervention Program on development of a database to which the newborn screening laboratory data can be exported, for potential linkage with the EHDI data.

QA/Technical assistance visits that were initiated in 2009 with the Newborn Screening Program Manager visiting 6 hospitals in 09 (7 first quarter 2010) and concurrently training three .05 FTE public health nurses to be able to help with these visits in the future and develop a Public Health nurse liaison relationship for perinatal and infant health issues will continue.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**27199**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	27131	99.7	5	3	3	100.0
Congenital Hypothyroidism (Classical)	27131	99.7	56	14	14	100.0
Galactosemia (Classical)	27131	99.7	2	0	0	
Sickle Cell Disease	27131	99.7	1	1	1	100.0
Biotinidase Deficiency	27131	99.7	5	5	5	100.0
Cystic Fibrosis	27131	99.7	27	8	8	100.0
SC-Disease	27131	99.7	5	5	5	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	27131	99.7	1	1	1	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	27131	99.7	1	1	1	100.0
21-Hydroxylase	27131	99.7	1	1	1	100.0

Deficient Congenital Adrenal Hyperplasia						
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	27131	99.7	3	3	3	100.0
S-Beta Thalassemia	27131	99.7	3	3	3	100.0
Hearing Screening	26824	98.6	1167	43	30	69.8
Short-Chain Acyl-CoA Dehydrogenase Deficiency	27131	99.7	3	3	3	100.0
B-Thalassemia Major	27131	99.7	1	1	1	100.0
C-Disease	27131	99.7	1	1	1	100.0
E-Disease	27131	99.7	1	1	1	100.0
Hyperphenylalanemia	27131	99.7	1	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	67.7	69.1	67	68.4
Annual Indicator	66.4	66.4	65.7	65.7	65.7
Numerator	326	326			
Denominator	491	491			
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	69.7	71.1	72.5	74	75.8

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Weighted data

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Weighted data

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Part C of the IDEA which in Nebraska is the Early Development Network, a collaborative relation between the Department of Health and Human Services and the Department of Education, completed a family survey to determine the satisfaction with services coordination and the services that were received. The program had a 59% return rate with families reporting high satisfaction in their services.

Data reported to OSEP (U.S. Office of Special Education Programs) October 1, 2008 indicated that Nebraska served 181 infants ages birth to 1 with disabilities, which is 0.66% of this population. The data also indicated that Nebraska served 1408 infants and toddlers, ages birth to three, which is 1.75% of this population, which shows progress over the number served in previous years. Source: Nebraska Part C Annual Performance Report FFY 2008

OSEP approximates that out of the general population, 1% of infants ages birth to one have special needs, and 2% of the general population of infants and toddlers ages birth to three have special needs. Nebraska's data appear to be cyclical without a defined pattern.

Through the Early Hearing and Detection Advisory Committee, Services Coordinators and Audiologists have been trained on collaborative practices and processes relating to EDN referrals and early intervention services. EHDI and EDN State program managers track related referral, intervention and outcome data on infants identified with a hearing loss between these 2 programs/systems. Since implementation of this collaborative process, EDN/Part C is serving 100% of all children identified with a hearing loss by the EHDI program.

Nebraska continued the comprehensive Child Find System, intended to enhance the identification, evaluation and assessment of infants and toddlers, birth to age three, with disabilities. Child Find is a state-led, regionally implemented set of activities to get early intervention information to the public, medical providers, schools, child protection services, Migrant and Early Head Start, tribal populations, homeless shelters and child care providers. Regional implementation of Child Find occurs through the Planning Region Teams. Systems Support/Change grants are provided to the Planning Regions to supplement funding for training and special projects including Child Find activities. Regions use several public information strategies for Child Find.

EDN Services Coordinators conducted data collection through Developmental TIPS for children that have been part of the program and are now entering first grade.

Research was completed on computerizing the an MHCP QA system. MHCP staff are working to implement a computerized process.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in Family to Family Health Information Center Advisory Board which partners with parents in working to streamlining communication and resources around the State. The Family to Family partnership works to provide support, information, res		X		X
2. Facilitate supporting parent leadership/mentoring activities to enhance Early Development Network Services.		X		
3. Continue to promote the comprehensive Child Find System through the Early Development Network.		X		
4. Continue the Early Childhood Interagency Coordinating				X

Council which collectively brings together stakeholders: schools, parents, families, policymakers, business, and civic organizations to establish a seamless continuum of early childhood care and				
5. Maintain Planning Region Teams to monitor and lead their area in working towards streamlined services and supports for children needing and receiving Early Intervention Services.				X
6. Maintain the Early Hearing Detection Advisory Committee which works along side parents to maintain an ongoing voice in enhancing hearing services for infants.				X
7.				
8.				
9.				
10.				

b. Current Activities

Expand the EDN program to provide additional supporting parent leadership/mentoring activities to enhance the services that are being provided.

EDN and MHCP programs continuing to promoting the medical home concept and assisting in professional development activities related to initiatives for infants, toddlers, and young children and young adults.

Continue through the Early Hearing and Detection Advisory Committee, Services Coordinators and Audiologists training on collaborative practices and processes relating to EDN referrals and early intervention services. EHDI and EDN State program managers track related referral, intervention and outcome data on infants identified with a hearing loss between these 2 programs/systems.

Collaborations and strategies are being developed to support a Youth Advisory Committee for the MHCP program.

Enhance to the QA process for the MHCP program to evaluate family access to care coordination services and identifying service gaps and barriers.

Continue building of the MHCP provider billing process to an on line billing system. This enhancement will provide a paperless system that both families and providers can access at any time to submit and track program billings. This system will also allow families to electronically approve provider hours and submit to the DHHS database.

c. Plan for the Coming Year

Continue parent collaborations with the Early Childhood Interagency Coordinating Council, The Regional Planning Teams, and the Early Hearing Detection Advisory Council.

Continue promotion of the comprehensive Child Find System.

Enhance the current MHCP clinic service survey to expand to all MHCP program services and recipients.

Develop strategies to implement a Youth Advisory Council for the MHCP program.

Implement a Transportation Brokerage to provide MHCP families with access to authorized supportive services through one statewide entity.

Provide training to MHCP staff and families on the transition to the Transportation Brokerage.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	55	55	56.1	55.2	56.4
Annual Indicator	53.8	53.8	54.2	54.2	54.2
Numerator	706	706			
Denominator	1313	1313			
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	57.5	58.6	59.8	61	62.2

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Weighted data.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Weighted data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
EDN Services Coordinators have applied their knowledge of the medical homes model in the provision of CAPTA services.

Active collaboration efforts were completed with Boys Town National Research Institute on the medical home pilot project which has entered the half way point. Work groups which include staff from the medical practice, parents, and local and state partners were provided training on the medical home model.

Provided MHCP staff and clinic providers with resource materials and supports on the medical home concept.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue participation in a multi agency work group regarding modifications to our CSCHN medical home program which is working with 10 pediatric medical practices across the State to transition those medical practices into medical homes for children	X			X
2. Assisted through the medical home collaboration project, placing paid parent partners in two of the medical home pediatric medical practices to assist parents accessing those practices with navigating programs and resources outside of the child's med		X		X
3. Apply knowledge of the medical home model in the provision of CAPTA services through the Early Development Network.	X	X		
4. Per LB 396, 2009 Nebraska Legislative Session, the Medical Home Pilot Program Act, the Governor has appointed a Medical Home Advisory Council to assist with a medical home pilot project in Central Nebraska.	X			X
5. Continue to promote and work to assist families in establishing a medical home provider through the Medically Handicapped Children's Programs Clinic Services.	X			X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continue participation with the Boys Town National Research Medical Home Pilot Project to develop a training tool for other pediatric medical practices across the state to use when transition their practice to a medical home.

Participate in the process of selecting two of the medical home pilot participants through the Boys Town Medical Home Project to acquire parent partner in two of the pediatric pilot sites to assist families in locating needed services and supports that are outside the scope of the medical practice.

Participate in the Nebraska Medical Home Pilot Project, per LB 396 of the 2009 Legislative Session, to build a medical home pilot project for the central part of the state for all children to test the efficiency and effectiveness of this service delivery approach.

The EDN and MHCP programs are working towards promoting the medical home concept and assisting in professional development activities related to initiatives for infants, toddlers, and young children and young adults.

c. Plan for the Coming Year
The MHCP program will be using the information from the medical home training sessions to educate families and medical clinic providers on the medical home concept. The information that will be provided will be used as a tool to assist families in screening and locating a medical home provider in their area

The MHCP program will be gathering information to work towards incorporating the medical home model into the medical clinic services that it provides to children and young adults with special health care needs.

MHCP continue to work in collaboration with Boys Town Medical Home Project to train the parent partners in two of the pediatric medical practices to assist families with accessing local services and supports outside the scope of the child's medical.

MHCP will put together strategies for sharing information and resources for families on medical home on the Answer4Families Website.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	65	66.3	67.2	68.6
Annual Indicator	63.5	63.5	65.9	65.9	65.9
Numerator	719	719			
Denominator	1133	1133			
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	69.9	71.3	72.8	74.2	75.6

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Weighted data.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Weighted data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Collaboration with Answers4Families provided resource information for family looking for medical providers and coverage services.

The MHCP program enhanced its data collection system, CONNECT, to add family income and household size to the client demographic page. This information will assist the program in increase the eligbility guideline above 185% of Federal Poverty.

Medicaid staff submitted an HCBS Waiver application to cover Early and Intensive Behavioral Intervention (EIBI) Services for children with autism spectrum disorder.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the expansion of Medicaid CHIP coverage to children and families with income up to 200% of the Federal Poverty Level under the authority of LB 603, 2009 Nebraska Legislative Session.		X		
2. Obtain income data from the CONNECT database for the Medically Handicapped Children's Program to increase the income guideline for financial eligibility.				X
3. Implement the Home and Community Based Autism Spectrum Disorder Waiver. The income guideline follows 185% of the federal poverty level, then income will be considered, on a sliding fee scale, in determining the amount of monthly premium the parent(s				X
4. Collaborate with Answers4Families website to provide information and outreach for clinic services for children with special health care needs. This will provide an overview of the clinics that are offered across the state as well as information on t				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
MHCP is gathering data from the enhancement to the CONNECT system to review family income information to assist in determining an increase in the current 185% eligibility guideline for the

program.

Medicaid eligibility expansion provides CHIP coverage to children in families with income equal to or less than two hundred percent of the Federal Poverty Level (FPL). Additional children will receive access to Medicaid services across Nebraska. Authority is provided through Legislative Bill 603 of the 2009 Nebraska Legislative Session.

Medicaid staff will be resubmitting a HCBS Waiver for autism services to incorporate changes authorized by the Nebraska Legislature in LB 27, 2009 session. Changes locate administrative responsibility with the Department of Health and Human Services. Provision of services in expected is expected to begin in 2010 following federal approval of the Waiver application.

MHCP participates in the Family to Family Health Information Advisory Board along with Answer4Families Website to provide families a place to access information and resources on obtaining health care services and coverage.

c. Plan for the Coming Year

MHCP will use the data gathered from the enhancement to the CONNECT system to review family income information to determine an increase in the current 185% eligibility guideline for the program.

Medicaid eligibility expansion will continue to provide CHIP coverage to children in families with income equal to or less than two hundred percent of the Federal Poverty Level (FPL). Additional children will receive access to Medicaid services across Nebraska. Authority is provided through Legislative Bill 603 of the 2009 Nebraska Legislative Session.

Medicaid staff will be implementing the HCBS Waiver for autism services which has been approved. The program will uses a variety of early intervention therapies for young children with autism to assist them in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Continue collaborative efforts with the Family to Family Health Information Center and Answers4Families Website to provide health care information and resources to families across Nebraska.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	80	81.4	83	93.7	95.6
Annual Indicator	79.8	79.8	91.9	91.9	91.9
Numerator	327	327			
Denominator	410	410			
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	97.5	99.4	100	100	100

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05. Weighted data.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05. Weighted data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
Part C of the IDEA which in Nebraska is the Early Development Network, a collaborative relation between the Department of Health and Human Services and the Department of Education, completed a family survey to determine the client's satisfaction with services coordination and the services they received. The return rate was 59% with high marks in satisfaction of services.

The MHCP program collaborated with the Parent Training Center and the Department of Education to develop strategies for the implementation of a Youth/Family Advisory Committee involving clients and/or their family members.

Continued enhancements to the Youth Panel Listserve on www.Answers4Families.org to discuss transitional issues and problem solve.

The Department established a Children and Family Support Hotline which shall be a single point of access for children's behavioral health triage through the operation of a twenty-four-hour-per-day, seven-day-per-week telephone line and provide referrals to existing community-based resources. It would also include the establishment of a Family Navigator Program with individuals trained to respond to children's behavioral health needs. Authority for these services is provided through Legislative Bill 603, 2009 Nebraska Legislative Session.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue a yearly survey of families who have a child enrolled in Early Development services for the previous year.				X
2. Collaborate with Answers4Families website to expand local resource listings to assist families in obtaining services in their area.				X
3. Maintain a hot-line system and a Family Navigator Program to respond to children's behavioral health needs per LB 603, 2009 Nebraska Legislative Session.				X
4. Implement a Transportation Brokerage that will allow parents to access authorization of supportive services through one statewide entity.				X
5. Maintain the Medically Handicapped Children's Program family survey of the clinic services they receive.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Strategies and collaborations developed with MHCP, the Parent Training Center, and the Department of Education will assist in the planning and development of a MHCP Youth/Family Advisory Committee.

The MHCP program collaborates with Answers4Families to assist in adding clinic specific information to their website for Nebraska families to access. Families are able to look for local MHCP clinics that would meet their child's health needs as well as provide them with information on clinic team members and their professional backgrounds.

The MHCP program continues to work with Answers4Families to expand a resource bank of Nebraska services based on the customers needs. Nebraska residents are able to log into the Answers4Families website and fill out a needs based assessment. From that assessment, the consumer would be directed to a link with local resources that can assist them in getting their identified needs met. MHCP, EDN, and Waiver service contacts will be listed.

A Network of Care website for behavioral health services has been established by the Behavioral Health Division in DHHS. This website will be a resource for individuals, families and agencies concerned with behavioral health. It will provide information about behavioral health services, laws, and related news, as well as communication tools and other features.

The Medicaid program continues to promoted the use of telehealth techniques as a way to improve access to care in rural areas of the state.

c. Plan for the Coming Year
Implement and develop a Youth/Family Advisory Committee to involve clients and/or their family members to assist in developing a process to add transition services into our current clinics and to provide client consultation to the program. The committee would also serve as a source for information outreach on the medical home model.

Maintain the Children and Family Support Hotline as a single point of access for children's

behavioral health triage through the operation of a twenty-four-hour-per-day, seven-day-per-week telephone line and provide referrals to existing community-based resources. It would also include the establishment of a Family Navigator Program with individuals trained to respond to children's behavioral health needs.

Work with regional collaborations on expanding telehealth services within the field of neurology for additional rural access to this specialized medical service.

Implement a Transportation Brokerage to allow families access to authorized program services using one statewide entity for access.

Provide training for MHCP staff and families on the transition in authorizing supportive services to the Transportation Brokerage.

The Early Development Network will administer a satisfaction survey reporting on services coordination and delivery of service.

The MHCP program will expand the parent clinic satisfaction survey into a tool that can be utilized for all program services and recipients.

Continue to enhance MHCP outreach services, program information, and supports through the Answer4Families Website.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	5.2	5.3	55.4	56.6
Annual Indicator	5.1	5.1	54.4	54.4	54.4
Numerator	118	118			
Denominator	2314	2314			
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	57.7	58.8	60	61.2	62.4

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern

revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. Weighted data.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. Weighted data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
The MHCP program continued to utilize HRSA materials to assist in educating MHCP staff on transition practices in our clinics and expanded their use to other programs (ie waiver workers, EDN Services Coordinators, and other specific case workers)

The MHCP program worked on strategies to implement transition services into each of the MHCP medical clinics.

A Young Adult Advisory Council (YAAC) specializing in adolescent health care and independent living transition continued. The YAAC provided policy input to HCBS Waiver staff related issues.

A Youth Panel Listserve continued on Answers4Families Website to discuss transitional issues and problem solve.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop and implement transition services into the Medically Handicapped Children's Programs clinic services.		X		X
2. Continue to utilize HRSA materials to assist in developing transitional services and expand their use to other programs (ie Waiver staff, EDN Services Coordinators, and other Department staff).				X
3. Collaborate with the Department of Education to expand the Young Adult Advisory Council to include medical transition services.				X
4. Implement the Medicaid Infrastructure Grant (MIG) to support employment for people with disabilities. Efforts of the MIG focus on training and employment for individuals with a disability.		X		X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
The MHCP program continues planning to incorporating a transition piece into the medical clinic services that it provides. The program is reviewing transition information to assist in determining what the best practice should be for incorporating transition services.

The MHCP and the Waiver programs continue to work on a resource database system through Answer4Families which will allow those that transitioning out of the programs a point of access for additional resources in their area.

Additional training will be provided to MHCP program staff on transition services to enhance the outreach of the services.

The MHCP program continues to evaluate the establishment of a medical home through care management services for those transitioning out of the program.

DHHS applied for renewed funding for a Medicaid Infrastructure Grant which promotes employment for workers with disabilities. Grant activities will address the needs of youth transitioning to adulthood.

Continued to utilize HRSA materials to assist in educating MHCP staff on transition practices in our clinics and expanded their use to other programs (ie waiver workers, EDN Services Coordinators, and other specific case workers)

c. Plan for the Coming Year
The MHCP program continues work on incorporating a transition piece into the medical clinic services that it provides.

The MHCP and the Waiver programs will finalize a resource database system through Answer4Families which will allow those that transitioning out of the programs a point of access for additional resources in their area.

Additional training will be provided to MHCP program staff on transition services to enhance the outreach of the services. The program will also determine the feasibility of putting health information collected from our clinic services to a zip drive that can be given to transitioning youth, allowing them access to their past medical history.

The MHCP program continues work to establish a medical home through care management services for those transitioning out of the program. This will ensure that each young adult that transitions out of our program has a medical home in place or the knowledge and tools to be able to acquire a medical home depending on their geographical location.

Continue the development of a Youth Advisory Council for the MHCP program to provide program service guidance and direct program impute.

Implement the Medicaid Infrastructure Grant to promote employment for workers with disabilities. Grant activities will also address the needs of youth transitioning to adulthood.

Continue to utilize HRSA materials to assist in educating MHCP staff on transition practices in our clinics and expanded their use to other programs (ie waiver workers, EDN Services Coordinators,

and other specific case workers)

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	83.9	85.4	86.9	83.5	83.6
Annual Indicator	89.1	81	85.2	74.8	64.9
Numerator					
Denominator					
Data Source				CDC NIS	CDC NIS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	76.2	77.8	79.4	80.9	82.5

Notes - 2009
Data is Q3/2008-Q2/2009. The entire 2009 data has not been released by CDC.

Notes - 2008
Data is Q3/2007-Q2/2008. The entire 2008 data has not been released by CDC.

Notes - 2007
Data is Q3/2006-Q2/200. The entire 2007 data has not been released by CDC.

a. Last Year's Accomplishments
It should be noted that CDC now uses a different standard than is stated for this national performance measure. In addition to the measure's listed vaccines, the CDC considers a full schedule of age appropriate immunization to include varicella and pneumococcal vaccines. The National Immunization Survey for calendar year 2009 won't be released until late August 2010. The data for NIS 2008 shows low vaccine coverage due to the long-term shortage of the haemophilus influenza type b vaccine. Data for 2009 will be similar due to the length of the Hib shortage. http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_0809.htm

In regards to accomplishments, the Nebraska Immunization Program is located within Lifespan Health Services. Primarily fundedthrough the CD, this program administers the 317 and Vaccine for Children (VFC) funds, as wellas Hepatitis B projects, both perinatal and adult. In FFY 2009, the program supported 86 counties with public clinics across the state, 45 public VFC providers and 218 VFC private providers.

The Program also transferred from a centralized system to a web-based state immunization information system (NESIIS) that includes all public immunization clinics and an increasing number of private providers that give immunizations to individuals regardless of age. Nebraska participated in the Hallmark Card program (a card signed by the Governor and First Lady and sent to the parents of all newborns with an immunization message).

Title V funds helped support the costs of the state immunization info system, which serves all providers
who immunize children and mothers from birth on throughout life. Birth data for births back to 2003 was loaded into NESIIS by Nebraska's Office of Vital Statistics with weekly updates. Staffs from all the school districts were trained on how to look up records in NESIIS. The NESIIS was used extensively during the H1N1 influenza season to capture H1N1 immunizations that were given.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported public immunization clinics and private VFC providers across the state.			X	
2. Fully mplemented new web based immunization information system, adding more private providers and linking with other data systems.			X	X
3. Continued participation in Hallmark Card program.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Nebraska Immunization Program continues to support 86 counties with public immunization clinics and 218 private VFC providers. The Immunization Program will use the allocation of Title V funds this year as partial support for the state immunization information system as it develops new modules and upgrades its functions, particularly the ability to download immunization data from other electronic health systems. New providers are being enrolled and trained throughout the state. Immunization records in NESIIS have increased from 250,000 last year to at least 800,000 records so far this year.

c. Plan for the Coming Year
Implementation of the web based immunization registry (NESISS) will continue in the private sector and for special populations and activities, such as refugee programs, international travel vaccinations, and emergency disaster response. Enhancements to the system will include perinatal Hepatitis B management module, bar coding of vaccine inventories, and other adjustment to the system to make it easier and more efficient to enter data.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	17.5	17.7	15.9	16.6	17.4
Annual Indicator	18.1	16.3	18.1	18.2	17.4
Numerator	690	616	687	671	633
Denominator	38097	37844	37863	36878	36349
Data Source				Birth File, Census Est.	Birth File, Census Est.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	17.1	16.7	16.4	16.1	15.7

Notes - 2008
Birth file is not complete or cleaned.

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

a. Last Year's Accomplishments
The Adolescent Health Coordinator continued oversight of the remaining term of a two-year contract that provided services to women who are pregnant or believe they are pregnant. Services targeted areas of the state with high teen pregnancy and STD rates, with reductions in teen pregnancies as one of the project's goals.
The Nebraska Abstinence Education Program continued as a result of the extension of federal funding through June, 2009. Ten (10) mini grants were awarded to entities and organization responding to an abbreviated application process. Most if not all recipients of the mini grant funds were grantees in previous years of the federal funding. These mini grants allowed for continuation of program activities previously implemented including curriculum training, guest speaker services and one-on-one abstinence education to teens within clinic environments. Implementation of programming planned for selected sites beginning September 2009 was abandoned due to the discontinuation of federal funding.

The Nebraska Adolescent Comprehensive System Initiative was launched in FY 2009. Two statewide stakeholder meetings were convened in March and June 2009. With the assistance of facilitators from the Konopka Institute and the Association of Maternal and Child Health Programs (AMCHP) and using Nebraska's Early Childhood Comprehensive System initiative as a blueprint, stakeholders identified the components of an adolescent system and the principles or assumptions of each component. An ad hoc group was convened to develop the initiative mission and vision statements as well as core functions and guiding principles. The Adolescent Comprehensive System has been designed in a manner so that each of the six components plays an integral role in addressing pregnancy and STDs among the state's adolescent population.

Nebraska Title X/Family Planning Delegates did not meet the "10% increase in adolescent unduplicated users" goal between 2008 and 2009. Total unduplicated adolescents served in the 15-17 age group was 1280 and total unduplicated users age 24 and under statewide was 10,156. The past few years has seen a downward slide in adolescent numbers being served by the Title X clinics supported through Nebraska Reproductive Health. The 10% goal was set with the hope

of stimulating some further outreach to that population. Individual Delegates saw some increase in adolescent numbers, but nothing significant. We did see a 25 user increase overall so 2009 could be seen as a maintenance year and a success as the continuous decrease in clients seems to have stabilized for adolescent users.

In 2009 Nebraska Reproductive Health continued work with a local public relations/marketing group to develop print and web media for the marketing of the statewide Title X program. A new print brochure describing statewide services and clinic sites has been printed and distributed to Title X Delegates. In addition information cards to discuss sexual coercion and parent involvement with adolescents have been updated and personalized for each Delegate through the State of Nebraska print shop.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided comprehensive reproductive health services through the NE Reproductive Health Program, including outreach and community education for adolescents.	X		X	
2. Conducted social markeing research and developed campaign to better reach at risk populations through Reproductive Health Program.			X	X
3. Continued youth development work and initiated development of Adolecent Comprehensive Systems strategic plan.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A new RFP seeking a contractor to deliver services to women who are pregnant or believe they are pregnant was released in October 2009. A contract was awarded to commence May 1, 2010. The winning bidder, having previously performed services under a pilot program, is concentrating efforts within the state's largest metropolitan area as well as expanding services within their eight satellite offices located statewide. Services are being delivered to those areas known to have some of the state's highest rates of teen pregnancy and STDs. Due to the expiration of federal funding in June 2009 there were no abstinence education activities developed or implemented during the current year.

The Nebraska Adolescent Comprehensive System continued in the planning phase with goal statements developed for two of the six identified system components and the remainder to be developed at the July 2010 stakeholder meeting. Reducing teen pregnancy and STD rates will be among those issues investigated by the data team as desired outcomes for one or more of the components. The Comprehensive System Initiative continues to gain recognition and support at the agency and national levels.

An application was submitted for Teen Pregnancy Prevention funding to enhance services at Nebraska's Title X/Family Planning clinics by implementing an evidence-based strategy targeted to high-risk teens. The "Safer Sex" modelwas chosen for the proposal. Notification on status of that application is pending.

c. Plan for the Coming Year
The Adolescent Health Coordinator will continue oversight of and assistance to the contractor selected to deliver services to women who are pregnant or believe they are pregnant. The strategies and activities implemented by the contractor for teen pregnancy prevention and the reduction of STDs will be incorporated into the collaborative partnerships being developed as a result of the Adolescent Comprehensive System initiative and the state's Title V priority needs.

New funding included in the federal health care reform legislation for like-kind programming is anticipated. Consideration will be given to applying for one of the competitive grants authorized by the legislation as a means of expanding and enhancing the work being done by the current contractor.

Youth development concepts that address teen sexual behaviors will be incorporated into the strategies and activities developed as a result of the Adolescent Comprehensive System Initiative. Addressing the identified desired outcomes for each of the system components, particularly those corresponding to teen sexual health will be executed within a youth development framework.

New funding to states as a result of the federal health care reform legislation is anticipated for FY 2011. Of this funding the Personal Responsibility Education Program (PREP) and the reinstating of Abstinence Education Programming provides the Adolescent Health program additional mechanisms to address teen pregnancy and the spread of STDs among the state's youth population. The PREP funding, if obtained, will be implemented in a manner supportive of the Adolescent Comprehensive System Initiative. Abstinence education programming, abandoned in FY 2010 due to discontinuance of federal funding will be restored.

The "Safer Sex" evidence-based strategy will be implemented in Title X/Family Planning clinics should Nebraska's Teen Pregnancy Prevention grant application be funded. Regardless, the program will continue its efforts to enhance services to teens, with further strategizing on better outreach, adolescent friendly service delivery, open-access scheduling (same day appt.) and marketing.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	45.7	46.8	47.8	48.9	50
Annual Indicator	44.6	44.6	44.6	44.6	44.6
Numerator	10489	10489	10489	10489	10489
Denominator	23518	23518	23518	23518	23518
Data Source				NE Open Mouth Survey 2004	NE Open Mouth Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	50

a. Last Year's Accomplishments
During FY2009, Nebraska Title V Block Grant funds for two purposes related to Dental/Oral Health: (1) to support distribution of dental health materials from the NDHHS Office of Oral Health and Dentistry to a variety of dental health providers and consumers and (2) increase access to preventive care among low-income children by providing preventive care to children.

(1) The Office of Oral Health and Dentistry distributed a total of 132,999 individual dental educational materials from October 2008 to September 2009. The materials distributed include printed items for adults and children such as brochures on dental care, activity booklets and items like stickers and bookmarks. The printed materials account for 95% of items distributed. The remaining 5% of materials were oral health items, such as toothbrushes and toothpaste samples.

(2) The other use was to support a contract (Oct 1, 2008 to June 30, 2009) with the University of Nebraska Medical Center, College of Dentistry to provide a school-based dental sealant program. The program provided oral health education, prophylaxis, dental sealants and fluoride treatments free of charge to children in second, third and sixth grades in selected schools. The selected schools were those with 70% or more of their students eligible for free or reduced lunch program. A total of 1,437 children in grades 2 through 6 were served, including 1,207 receiving sealants and 1,386 receiving fluoride treatments.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Supported school-based sealant, flouride treatment, and education program in selected schools.			X	
2. Provided educational materials on children's oral health to stakeholders and providers.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
During FY2010, Title V funds were allocated to support the position of Director of the NDHHS Office of Oral Health and Dentistry. Kären Sorenson, DDS was hired under contract to develop policy, build partnerships, and provide state-wide direction for all oral health activity. Her hiring followed a three-year-long vacancy in the position, and has re-invigorated the Office of Oral Health and Dentistry.

Also during FY2010, Preventive Health and Health Services (PHHS) Block Grant funds were allocated to support two preventive dental projects aimed at children and operated by two local

health departments. The two agencies are Two Rivers Public Health Department and South Heartland District Health Department.

Beginning Sept 2009, a 3-year, $1.5 million award from HRSA has enabled NE to address the access barriers to preventive dental care among children under the age of 8. During the 10 months of operation, NE has: added Dental Health Coordinator and Dental Health Assistant positions to the Office of Oral Health and Dentistry; formed an Advisory Panel made up of oral health stakeholders; developed a system to track dental materials and Dental Health Events; developed a survey to determine the availability and interest among Nebraska's Dental Hygienists in serving in dental public health settings: developed the process by which local entities may apply for funds to solve local dental health access shortages; and updated the Nebraska Public Health Dental Clinic Directory.

c. Plan for the Coming Year

During FY2011, Nebraska plans to continue to fund dental health at a similar level with similar goals; MCH Block Grant Funds will be allocated to support the contract with the Director of the Office of Dental Health, PHHS Block Grant funds will support local preventive dental projects and the HRSA funds will support the infrastructure of the Office of Oral Health and Dentistry and support local entities' in providing preventive services to children under the age of 8 years.

With access to oral health newly identified as a priority for Nebraska, additional strategies will be explored. During the public comment period for this application, a number of recommendations were made regarding school based dental clinics, particularly Title I schools. One commentor pointed out that recent changes in scope of practice for dental hygienists and new Medicaid reimbursements for flouride varnish would help support oral health services in schools. Another commentor suggested implementing a program like the "Kansas Cavity Free Kids" project which brings portable equipment into the Head Start and Early Head Start programs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.4	3.8	3.4	3.4	3.3
Annual Indicator	5.3	3.8	4.1	1.7	3.4
Numerator	18	13	14	6	12
Denominator	338806	339983	341855	343908	349420
Data Source				Death file, Census Est.	Death file, Census Est.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	3.2	3.1	3	2.9	2.8

Notes - 2009
2009 death file in not complete.

Notes - 2008
2008 death file in not complete.

Notes - 2007
2007 Death file is incomplete, missing out of state deaths and few thousand causes of death.

a. Last Year's Accomplishments
The Safe Kids Nebraska program is responsible for carrying out unintentional injury prevention activities for children 14 and under. One of the programs provided is Safe Kids Buckle Up, which focuses on child passenger safety. Monetary support comes from the Preventative Health and Human Services Block Grant, Safe Kids Worldwide, General Motors, Nebraska Office of Highway Safety as well as local sponsors.

In 2009, child passenger safety certification trainings were held in Scottsbluff, Kearney, Omaha, Norfolk, Grand Island and Lincoln. A total of 87 participants were certified. These courses have been implemented since 1999 in Nebraska. These activities have contributed to more children being in car seats from 93% in 2007 to 95.4% in 2009. This is a significant increase from 1999 at which time only 56% of children were restrained. Currently, there are over 375 Certified Child Passenger Safety Technicians across the state. The Safe Kids program provides technical assistance and grant opportunities to these technicians and their communities. Certification courses are sponsored by Safe Kids and Nebraska Office of Highway Safety through grants and staff time.

The Nebraska Office of Highway Safety and Safe Kids Nebraska co-hosted a Child Passenger Safety Technician update in Kearney, Nebraska with over 200 technicians from across the state in attendance. In conjunction with the update, a NHTSA School Bus Safety training was held; 22 individuals completed that training and will be available to assist others in the state and their communities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promoted child passenger safety through the Safe Kids program, including child safety seat check events.			X	
2. Conducted National Highway Traffic Safety Adminstration certification courses for safety seat checks.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Nebraska Office of Highway Safety is supporting statewide child safety seat checks by funding 19 fitting stations and five child passenger safety certification classes. Currently, classes

have been held in Scottsbluff, Omaha and Grand Island. Additional classes will be held in Omaha and Lincoln. At year's end, about 85 more technicians from various agencies will be trained.

The Safe Kids Buckle Up program continues to support Safe Kids programs throughout the state with funding to plan and implement child passenger safety into their communities. Child Passenger Safety events are held routinely in these communities along with advocacy trainings, educational events for parents/caregivers, and presentations.

c. Plan for the Coming Year
The Nebraska Child Passenger Safety Advisory Committee will convene its meetings in the fall to discuss the 2011 training schedule as well as other issues affecting child passenger safety. Safe Kids Nebraska will continue to utilize Safe Kids Buckle Up grants to help communities conduct child safety seat check events, educational programs as well as trainings.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		35.8	48.8	56	66.5
Annual Indicator	35.1	47.9	55.1	65.2	46
Numerator					
Denominator					
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	47	48	49	50	51

Notes - 2009
80.01% of woman reported initiating breastfeeding of those 46% reported breastfeeding longer than 180 days. However, only 32.5% reported exclusive breasting over 180 days.

Notes - 2008
76.42% of woman reported initiating breastfeeding of those 65.2% reported breastfeeding longer than 180 days. However, only 35.3% reported exclusive breasting over 180 days.

Notes - 2007
Data source is CDC's National Immunization Survey, 2006 (weighted data).

a. Last Year's Accomplishments

In 2009 Breastfeeding peer counselor programs continued to serve clients in four WIC local agencies in Nebraska -- Central District Health Department in Grand Island, Family Service WIC in Lincoln, Douglas County Health Department in Omaha, and Western Community Health Resources in Chadron. In addition to providing client services, breastfeeding peer counselors in these agencies developed and participated in breastfeeding promotion and support activities throughout their communities and collaborating with community partners whenever possible.

Title V funds supported the development of Nebraska's Breastfeeding Coalition. A contractor with expertise in organizational development carried out the following activitites: researched similar coalitions in other states and presented options for structure; facilitated meetings to formulate mission, vision, values and goals; developed a database of contacts and a format for on-going communication; identified potential partners, established membership and partnership forms and guidelines; produced a case statement in PowerPoint; helped to write success stories; helped to develop a website, www.nebreastfeeding.org; created collaborative leadership model, work plan, and resource development plan; designed a job description for an administrative assistant and a plan for a "virtual office" ; and connected with an established organization to launch the Coalition at a biennial conference. The results of these activities were that: opt-in contact list grew from 60 to 130 names three months after Coalition launch; coalition received support through two grants that funded website development, administrative services, and special projects; and seed money was raised through memberships and donations at launch event and resources continue to grow

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided peer counseling services at 4 WIC local agencies.	X		X	
2. Through a contract funded by Title V, Nebraska Breastfeeding Coaltion formed.				X
3. Workplace supports for breastfeeding included in two community based Title V projects.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FFY 2010, the WIC program received additional federal funding allowing the breastfeeding peer counseling program to expand to 8 additional WIC Local Agencies, for a total of 12 agencies. The 8 newly funded WIC local agencies are in process of implementing their new peer counseling programs, including recruiting, hiring, and training new peer counselors, training WIC staff, and promoting the peer counselor program within their communities. On October 1, 2009 the WIC program implemented the new WIC food package which includes specific guidance and food package changes for breastfeeding mother and baby pairs. The WIC Program worked on action steps of the five-year goal to increase the percent of exclusively breastfed infants.

In September 2010, local agency breastfeeding coordinators will attend a training event designed to teach them how to train staff using the "Loving Support to Grow and Glow in WIC" Breastfeeding Training for Local WIC Staff curriculum. In April 2010, 200 WIC staff attending the WIC/CSFP annual meeting attended the session "How WIC Supports Breastfeeding" to complete

the first module of the "Grow and Glow" training curriculum. A breastfeeding promotion and support campaign, "Breastmilk; Every Ounce Counts" will be implemented in all WIC local agencies.

The Nebraska Breastfeeding Coalition is in place with members routinely meeting and working on collaborative projects.

c. Plan for the Coming Year

All WIC staff in Nebraska will be trained using the "Loving Support to Grow and Glow in WIC" breastfeeding training curriculum. Each local agency will be responsible for completing training for their agency staff. The focus on promoting and supporting exclusive breastfeeding, especially in the first month of life will continue throughout FY2011. Action Steps related to the statewide breastfeeding goal for the WIC State Plan: By August 1st, 2013, increase the percent of exclusively breastfed infants at 6 months of age, will continue. State WIC program and Perinatal, Child and Adolescent Health staff will continue participation in the Nebraska Breastfeeding Coalition.

With breastfeeding duration identified as one of Nebraska's priorities for the next 5 year period, and many suggestions were received on this priority during the public comment period for Nebraska's Title V application. Recommended strategies included increased access to lactation consultants and peer support; affordable access to hospital-grade pumps; more prenatal education on breastfeeding; adding a requirement for child care providers to have an annual training on breastfeeding; establishing a breastfeeding helpline; more education for health care providers; insurance coverage for pumps and pumping supplies; remove forumla promotions from hospitals and physician offices; and promote workplace supports to more employers. These potential strategies will be evaluated in partnership with Nebraska's Nutrition and Physical Activity for Health Program. This CDC-funded program administered in the Health Promotion Unit shares breastfeeding promotion as a priority issue.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	99	99.7	99	99.9	100
Annual Indicator	99.6	98.9	99.0	99.3	98.9
Numerator	26179	26615	26669	26791	26804
Denominator	26293	26898	26948	26972	27103
Data Source				Program Data	Program Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Of the 151 infants not screened 7 were refusals. The denominator is births - 112 infant deaths.

a. Last Year's Accomplishments
Nebraska Revised Statute SS71-4742 established that newborn hearing screening would voluntarily become the standard of care and that 95% of newborns would be screened for hearing prior to hospital discharge. During calendar year 2009, 100% of the 58 birthing facilities were conducting newborn hearing screening and all but one were conducting the screenings during the birth admission. Hospitals reported screening the hearing of 98.9% of the newborns during birth admission. The average refer rate was 4.3%. Outpatient re-screenings and/or diagnostic evaluations were completed for 85.1% of those needing follow-up services. Follow-up services were initiated at an average of 30.8 days of age. There have been 38 infants identified with a permanent childhood hearing loss, an incidence of 1.4 per thousand newborns. The average age of identification was 74.2 days, with 72.5% diagnosed prior to 3 months of age. Of the 38 infants identified with a permanent hearing loss, 60.5% were verified for special education services through Part C and 95.6% of those were verified prior to 6 months of age. Of the infants identified with permanent hearing loss, 69.0% were identified as having a medical home.

During this time period, a primary focus of the NE-EHDI Program has been to strengthen family support for families with young children recently identified with hearing loss. Progress toward establishing a Guide By Your Side program to provide family-to-family support was temporarily put on hold until the state chapter of Hands & Voices is better able to implement a project of this size. The first parent weekend workshop, Roots and Wings, was held in March, 2009, for parents of young children with hearing loss. It was attended by 17 families and received excellent participant ratings. It was developed through a contractual arrangement with Boys Town National Research Hospital. A "coordinated point of entry" for families into the early intervention system continued to be implemented. The Family Support workgroup, a formal sub-committee of the NE-EHDI Advisory Committee, continued to take a guidance role in developing the EHDI family support system.

The Nebraska Children's Hearing Aid Loaner Bank (NCHALB) completed its second year of operation. A partnership between the University of Nebraska-Lincoln (UNL) audiology department, the Nebraska Association for the Education of Young Children (NeAEYC) and the NE-EHDI Program, the NCHALB has 65 new digital hearing aids in stock and has served 63 children ranging in age from 2 months to 9 years of age from across the state. Funding for permanent amplification has been found for eight of the children. Private and foundation donations have begun to be received.

The NE-EHDI data system, an integrated module of the state's Vital Records ERS-II system, continued to be revised to provide for improved functionality for the users in the birthing facilities. A supplemental database to more economically create correspondence to the Primary Health Care Providers (PHCP) and parents, as well as to more easily generate status reports, was implemented on a limited basis.

Procedures to retrieve the newborn dried blood spot (DBS), prior to its destruction at 90 days, for identification of congenital cytomegalovirus (CMV), Connexin 26 and 30, mitochondrial, and Pendred syndrome continued to assist in establishing the etiology of a congenital hearing loss. To provide the Newborn Screening and the NE-EHDI Advisory Committees with the information to develop evidence-based recommendations for further use of the DBS to identify congenital CMV and to develop an audiologic monitoring system, the University of Nebraska-Lincoln audiology program was contracted to develop recommendations based on the literature

review and surveys of Nebraska audiologists, hospitals, and laboratories.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administered Newborn Hearing Screening Program as per NE Rev. State 71-4742, including reporting and tracking provisions.			X	
2. Promoted periodic screening of older infants and toddlers through Hearing Head Start and Hear and Now projects.			X	
3. Held first parent weekend workshop, Roots and Wings, in March, 2009, for parents of young children with hearing loss.			X	
4. The Nebraska Children's Hearing Aid Loaner Bank (NCHALB) completed its second year of operation.	X		X	
5. NE-EHDI data system, an integrated module of the state's Vital Records ERS-II system, continued to be revised to provide for improved functionality for the users in the birthing facilities.				X
6. Procedures to retrieve the newborn dried blood spot (DBS), prior to its destruction at 90 days, for identification of congenital cytomegalovirus (CMV), Connexin 26 and 30, mitochondrial, and Pendred syndrome continued to assist in establishing the et				X
7.				
8.				
9.				
10.				

b. Current Activities
Current program objectives are to:

Fully expand the integrated electronic data reporting system to support the electronic reporting of audiologic results and to strengthen linkages with related early childhood data systems.

Provide quality assurance reports, including comparison on key measures and short term outcomes, to birthing facilities quarterly and include technical assistance comments.

Continue training birthing facility staff to reduce the number of infants who are lost to follow-up.

In partnership with the University of Nebraska-Lincoln and Nebraska Association for the Education of Young Children, continue expansion of the Nebraska Children's Hearing Aid Loaner Bank for young children recently identified with a permanent hearing loss.

Continue implementation of the coordinated point of entry for parents of children recently identified with a hearing loss in partnership with the Early Development Network (Part C) and other partners.

Develop a website for the Early Hearing Detection and Intervention Program.

Conduct a second parent weekend workshop for parents of young children recently identified.

Implement multiple effective strategies to reduce the number of babies who are lost to follow-up with new supplemental funding from HRSA/MCHB.

c. Plan for the Coming Year
With the benchmark of 95% of newborns screened during birth admission having been consistently met, program activities for calendar year 2011 will continue to focus on implementing the ongoing mandates of Nebraska's Infant Hearing Act: expansion, enhancement and maintenance of the reporting and tracking system, collection of required data, application for federal funding, and providing consumer and professional education. The goals and objectives identified in the federal funding applications (HRSA/MCHB and CDC/NCBDDD/EHDI) will be implemented to reduce the loss to follow-up rate by furthering the development of the screening, diagnostic and services systems; expanding the reporting and tracking system, linking with other child data systems; and refining the quality assurance mechanisms.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12.2	11.3	12.3	13.6	15.9
Annual Indicator	11.5	12.6	13.9	16.2	19.0
Numerator	18000	19000	22000	24000	30000
Denominator	156000	151000	158000	148000	158000
Data Source				Census	Census
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	18.6	18.2	17.8	17.5	17.2

a. Last Year's Accomplishments
During the 2009 legislative session, LB 603 was passed and signed into law. This bill encompassed a number of child health and wellbeing provisions, particularly related to behavioral health. But it also included an expansion of Medicaid/SCHIP coverage by increasing income eligibility for children to 200% of poverty, from the previous level of 185%. This change went into effect late summer 2009. Nebraska SCHIP continues to be a Medicaid expansion.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. LB 603 was passed and signed into law. This bill encompassed a number of child health and wellbeing provisions, particularly related to behavioral health. But it also included an expansion of Medicaid/SCHIP coverage by increasing income eligibility f	X		X	X
2.				

3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Expanded income eligibility for Medicaid was in place during FFY 2010. The Patient Protection and Affordable Care Act (PPACA) is currently being assessed for its impact on and implications for Nebraska's populations, including MCH and CSHCN.

c. Plan for the Coming Year
The interplay of PPACA and State budgetary challenges is difficult to project. From the Title V MCH/CSHCN perspective, the focus will be on better understanding the issues and impacts, and collaborating with both Medicaid and stakeholders on education and awareness among families and providers.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		32	31.4	33.7	35.7
Annual Indicator	32.9	33.5	34.4	36.4	38.1
Numerator	4848	5036	5263	6204	4928
Denominator	14724	15028	15311	17034	12918
Data Source				NE WIC	NE WIC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	37.1	36.6	35.8	35.1	34.4

a. Last Year's Accomplishments
The current five-year nutrition goal selected to be worked on by the state WIC agency and all Nebraska Local WIC agencies is related to decreasing the rate of childhood overweight and obesity: By August 1, 2013 reduce the percentage of Nebraska WIC children ages 2-4 that are at or above the 85th percentile BMI-for-age. Strategies for this goal are: Using a family feeding dynamics approach to provide nutrition education and encourage family lifestyle behaviors that

increase physical activity. In April 2009, 120 WIC nurses and nutrition staff attended a two-day training session on family-feeding dynamics with emphasis on division of responsibility in feeding, eating competence, and strategies for WIC to work with clients to promote healthy weight in children.

Other programs addressed healthy weight among children in this age group who may or may not be participating in WIC. Two Title V-funded community-based projects are carrying out such projects, one targeting young children in child care settings and the other implementing neighborhood-wide interventions.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 120 WIC nurses and nutrition staff attended a two-day training session on family-feeding dynamics with emphasis on division of responsibility in feeding, eating competence, and strategies for WIC to work with clients to promote healthy weight in chi			X	
2. Two Title V-funded community-based projects are carrying out such projects, one targeting young children in child care settings and the other implementing neighborhood-wide interventions.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In April 2010, 120 WIC nurses and nutritionists attending the WIC/CSFP meeting attended a session focusing on pediatric obesity and the incidence of type II diabetes. On October 1, 2009 the new WIC food package was implemented. The new food package provides reduced fat or low-fat milk for children 2-4 years of age and women. The food package also includes a cash value voucher for purchase of fresh fruits and vegetables, and emphasizes whole grains including brown rice and whole wheat bread. Nutrition education materials and messages encouraging increased fruit and vegetable consumption were provided to all WIC Local Agencies as part of food package implementation and training.

The Nutrition and Physical Activity for Health Program, with ARRA funding, launched an initiative to promote healthy weights in family home-based child care settings.

c. Plan for the Coming Year

The WIC Program will continue to work on action steps of the five-year goal to reduce the percentage of WIC children ages 2-4 that are at or above the 85th percentile BMI-for-age, including implementation of nutrition messages targeted toward limiting consumption of sugar sweetened beverages and increased physical activity.

The WIC Program will continue to participate in activities of the SNAC plan for USDA programs and participate in bi-annual meetings of the Community Nutrition Partnership Council. In FY2011 the SNAC plan will include action steps to implement the "543421 GO" project (participants focus

on achieving 5 servings of fruits and vegetables, 4 servings of water, 3 servings, of low-fat dairy products, 2 hours or less of screen time, and 1 hour or more of physical activity each day)and share materials among members.

The Title V funded projects will be completing their 3rd and final year. The Lifespan Health Services Unit will work with the Health Promotion Unit's Nutrition and Physical Activity for Health Program to sustain their respective efforts with early childhood programming.

A new opportunity to impact healthy weight among children will include a performance improvement project through Medicaid Managed Care. Two new managed care contract go into effect August 1, 2010, and managed care expands from 3 counties to 10. The first quality assurance project to be undertaken with the new contractors will be focused on pediatric obesity. Title V staff will be working with NE DHHS Medicaid Managed Care staff in devloping and monitoring this project.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		11.9	11.7	11.3	11.5
Annual Indicator	12.2	11.8	11.6	11.8	10.6
Numerator	3186	3148	3122	3184	2852
Denominator	26143	26629	26935	26992	26931
Data Source				Birth file	Birth file
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10.3	10.2	9.9	9.8	9.6

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

a. Last Year's Accomplishments
Beginning December 10, 2008 Nebraska Medicaid covered counseling and certain drugs specifically approved to help clients quit using tobacco. In order for a Medicaid client to be eligible to receive Medicaid coverage of the drug product, the client must be at least 18 years of age and must be enrolled and actively participating in the Tobacco Free Quitline. There is a special protocol for pregnant women enrolled in the Medicaid program. Pregnant women do not receive medication, but have unlimited use of the Tobacco Free Quitline, and may access the tobacco cessation counseling visits.

Sixty percent (60%) of all of the calls to the Tobacco Free Quitline receive Medicaid benefits, and the calls to the quit line increased after the above service was implemented. The data from the quit line is analyzed as an aggregate due to HIPAA, so it is unknown how many pregnant women completed the counseling service, but approximately 60% of the total calls to the quit line are

women. See Current Activities below.

Overall, 60% of the callers are women, 30% are men, and the remaining callers do not reveal their gender. Between July 1, 2009 and April 30, 2010, nine pregnant women accessed the quitline, and seven breast feeding women accessed the quitline. However as reported earlier, it is unknown if they completed the counseling.

Between July 1, 2009 and December 17, 2009, 56% or 439 callers were between 18-44 years of age, 10.4% of the callers were between 18-24 years of age, 15.3% were between 25-29 years of age, and 31.2% were between 30-34 years of age. As for educational level, 32% of the callers had completed high school or received their GED.

On June 1, 2009, the Clean Indoor Air Act went into effect and Nebraska became the 16th state to require indoor workplaces in Nebraska to be smoke-free. The purpose of the Act is to protect the public health and welfare by prohibiting smoking in public places and places of employment. The Act eliminates smoking in enclosed indoor workspaces including restaurants, bars, keno establishments, other workplaces (retail/office space, manufacturing, etc.) and indoor public places.

Nebraskans overwhelmingly support the law, and a six month report was published in January 2010. See Current Activities below.

More information about this act can be found at: http://smokefree.ne.gov.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nebraska Medicaid covered counseling and certain drugs specifically approved to help clients quit using tobacco.	X			
2. Pregnant women do not receive medication through Medicaid, but provided unlimited use of the Tobacco Free Quitline, and may access the tobacco cessation counseling visits.			X	
3. The Clean Indoor Air Act went into effect and Nebraska became the 16th state to require indoor workplaces in Nebraska to be smoke-free.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Tobacco Free Nebraska has recently developed a web site devoted to tobacco cessation. This web site can be found at: http://www.dhhs.ne.gov/tfn/ces

Web coaching services will begin in August. Tobacco users will be able to access counseling via the web if they prefer a web site over the quitline, or quitline users can receive additional counseling services through the web site.

Based on the data collected for the Six Months of Smoke-Free Air report: there is public support for the law; people recognize the importance of the law; the public believes that the law is making

work place healthier; the frequency of going to bars, restaurants and gaming establishments is not significantly impacted by the law; for some tobacco users, the law is an impetus to quit smoking; and the full report can be found at: http://smokefree.ne.gov

Lifespan Health Services supports these activities in the Nebraska Tobacco Free Program; staff continues to provide tobacco cessation resource materials to providers at no cost.

c. Plan for the Coming Year
Nebraska Title V and Tobacco Free Nebraska will continue long-standing collaborations to promote tobacco prevention and cessation within the MCH populations. New initiatives will be developed as resources permit.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.5	13.4	13.1	12.8	12.9
Annual Indicator	13.7	16.1	11.5	13.2	10.0
Numerator	18	21	15	17	13
Denominator	131107	130338	130506	128885	130498
Data Source				Death file, Census Est.	Death file, Census Est.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12.6	12.4	12.1	11.9	11.6

Notes - 2009
Three year rolling average.

Notes - 2007
2007 Death file is incomplete, missing out of state deaths and few thousand causes of death.

I have switched to a three year rolling average based on reviewer recommendation.

a. Last Year's Accomplishments
The Suicide Prevention Coalition began implementation of the LOSS (Local Outreach to Suicide Survivors) program in July 2009. This program brings immediate support to survivors as close to the time of death as possible. The teams, made up of two suicide survivors and one mental

health professional, have responded to an average of 2 calls per month.

The SOS (Signs of Suicide) Program, a school-based suicide prevention program, was implemented in the Lincoln Public School System. The State School Nurse Consultant, Lifespan Health Services Unit, has become involved in the State Suicide Prevention Coalition. This has helped facilitate work within schools in Nebraska.

On June 19, 2009, the Suicide Prevention Coalition hosted a forum on youth suicide prevention and the role of schools, inviting school health, mental health, and safety professionals to engage with the coalition in identifying issues facing schools and youth and strategies to better engage school partnerships in prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Suicide Prevention Coalition began implementation of the LOSS (Local Outreach to Suicide Survivors) program.			X	
2. The SOS (Signs of Suicide) Program, a school-based suicide prevention program, was implemented in the Lincoln Public School System.			X	
3. The Suicide Prevention Coalition hosted a forum on youth suicide prevention and the role of schools, inviting school health, mental health, and safety professionals to engage with the coalition in identifying issues facing schools and youth and strat				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Nebraska received the Garrett Lee Smith funding from SAHMSA for youth suicide prevention. This has been the result of a collaborative effort between the Suicide Prevention Coalition, Nebraska Department of Health and Human Services Division of Public Health and the Division of Behavioral Health, Nebraska Interchurch Ministries, and the University of Nebraska Public Policy Center. Current efforts include awarding local seed grants to local communities and targeting efforts to returning military. As part of that funding, QPR training has been held in several locations around the state. A specific initiative of the QPR Gatekeeper training has been to reach Nebraska's school nurses. Between March 2010 and June 2010, a total of 95 school nurses completed QPR Gatekeeper training in 7 regional locations statewide.

The Statewide Suicide Prevention Coalition hosted the Nebraska Suicide Prevention Summit in January, 2010. Including those participating in 25 telehealth sites, over 200 individuals participated. The goal of the event was to provide an overview of suicide as a public health concern in Nebraska, present opportunities to discuss local needs related to suicide prevention, and featured an introduction to best practices in suicide prevention. As a result of the summit, several communities have formed local suicide prevention coalitions.

c. Plan for the Coming Year
Additional seed grants will be awarded to communities through the Garrett Lee Smith grant. Several of these include efforts to begin LOSS teams in other communities.

Continued engagement by the coalition with the state school nurse consultant and the Dept. of Education's school safety coordinator are integral to plans to continue raising awareness among school officials about suicide among youth and suicide prevention resources available to schools.

The continued involvement of the school nurse consultant will provide an opportunity to continue reaching and involving school health professionals with resources and information.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	74.3	78.2	73.7	69.2	69.8
Annual Indicator	74.6	71.9	68.1	63.5	57.9
Numerator	217	218	220	207	184
Denominator	291	303	323	326	318
Data Source				Birth file	Birth file
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	59	60.2	61.4	62.7	64

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

a. Last Year's Accomplishments
Though the following activities occurred prior to FY 2009, it is being included as background.

All UNMC/UNO Master of Public Health Program students must complete a service learning capstone project. In 2007, a student completed her capstone project that focused on Nebraska's perinatal system. The project produced a description of the current status of regionalized perinatal services in Nebraska. Specifically, there were two parts to the project. The first was a literature review of the historical and current status of perinatal regionalization nationally. Essential background for this part was the national Guidelines for Perinatal Care, Fifth Addition, American Academy of Pediatrics and The American College of Obstetricians and Gynecologists, for definitions of and guidelines for levels of care, supplemented with current research and position papers on perinatal regionalization. Next was an in depth examination of the current Nebraska system. With the guidance of Lifespan Health Services staff and others, the student gathered information from applicable DHHS programs such as Medicaid, from Nebraska hospitals, and from Nebraska health care provider organizations. This capstone project provided a detailed description of the current status of perinatal regionalization in Nebraska.

During 2008, a second College of Public Health student continued work on levels of care as her Capstone project. Using the data gathered in 2007, the second student 1) Examined the distribution of births in Nebraska over a 5-10 year time period according to hospital level of care criteria (3 groups categorized by level of maternity and neonatal care services); 2) Examined the distribution of low birth weight and very low birth weight births in Nebraska over a 5-10 year time period according to hospital level of care criteria; and 3) Examined the distribution of low birth weight babies born in level I and II hospitals that are transferred for care according to the birth certificate data. The public health questions explored included: should hospital administration recommend referring mothers with infants at risk for low birth weight to level II and III hospitals for delivery and neonatal care? Who should be referred and when?

Among the findings of this research were that: 61.4% of LBW, VLBW and ELBW infants were born in level 3 facilities compared to 40.2% of NBW infants; 2.7% of all births and 15.5% of LBW births were transferred either pre- or post-natal; the majority of the LBW infants were transferred to hospital level of care 3 (79.18%) compared to hospital level of care 2 (8.75%); among infant deaths, 8.2% had a maternal transfer as opposed to 0.6% of surviving infants; about 75.9% of the total infant deaths occurred in situations where neither mother nor infant was transferred; and insulin-dependent diabetes, uterine bleeding and genital herpes were the main factors associated with maternal (prenatal) and/or newborn transfer. Preliminary conclusions included a possible need for providers to perform more systematic risk assessment regarding the need for prenatal transfers. Further research was determined necessary to examine whether mortality results differ for neonatal deaths versus the larger category of infant deaths.

No additional work was done with this information due to limited manpower and competing demands.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Analysis of data related tolocation of delivery, transport of mothers andinfants, and infant outcomes remained available for strategy development; further action delayed during 2009.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A new perinatal nurse specialist has joined the staff, and is being oriented to a wide range of systems issues, including the findings of the studies described above. In the meantime, competing demands have limited work on addressing this issue during this current year.

c. Plan for the Coming Year

With access to and quality of perinatal health services emerging as one of Nebraska's ten priority issues as a result of the recently completed needs assessment, perinatal regionalization will be

further explored within the range of perinatal issues of pre- and inter-conception care, prenatal care, and labor, delivery and postpartum care.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84.6	79.3	80.9	74.8	73.6
Annual Indicator	77.8	71.5	73.2	72.1	72.0
Numerator	20332	19096	19721	19464	19382
Denominator	26144	26723	26935	26992	26931
Data Source				Birth file	Birth file
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	75.1	76.6	78.1	79.7	81

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births). Over 2% of the data for this PM is missing/unknown.

a. Last Year's Accomplishments
The MCH/CSHCN Strategic Planning Workgroup that addressed preterm births and very low birth weight outlined strategies that focused on pre and inter-conception health care. Thus the emphasis on reaching women even before pregnancy continued. These strategies were incorporated into the RFA for community-based MCH projects issued in May 2008. One of the selected projects included enhanced family planning visits with preconception risk assessment and reproductive health plan. This project also seeks to increase access to early prenatal through the use of a community-based Care Line and referral to physicians. A prenatal care project was also selected that expanded its scope of services to include pre- and inter-conception care. These projects continued in FY 2009.

During FY 2009, a separate work group was formed to examine infant mortality disparities. Two logic models were developed. One focused on social supports at the personal, family, community, and societal levels. The other detailed needed system level changes related to access, quality and utilization. The latter emphasized community-based participatory research and community action to address system issues such as health equity. Actions to implement these strategies during FY 2009 were limited because the work was completed late in the year, and time and manpower were then shifted to the needs assessment.

Lifespan Health Services carried out activities through its First Time Motherhood/New Parents Initiative grant. The project focuses on messaging to women 15-24 who are uninsured or at risk of being uninsured, and was funded for a two year period, beginning September 2008. During FY 2009 a contractor completed studies with Nebraska women in the targeted age group and designed concepts to better engage and inform them of life course planning. The intent is to promote better health related behavior during the preconception period, resulting in fewer

unintended pregnancies, a risk factor for late entry into prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCH/CSHCN Strategic Planning Workgroup that addressed preterm births and very low birth weight outlined strategies that focused on pre and inter-conception health care. Thus the emphasis on reaching women even before pregnancy continued. These st			X	
2. A work group was formed to examine infant mortality disparities. Two logic models were developed. One focused on social supports at the personal, family, community, and societal levels. The other detailed needed system level changes related to acce				X
3. Carried out activities through its First Time Motherhood/New Parents Initiative grant. The project focuses on messaging to women 15-24 who are uninsured or at risk of being uninsured,			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Lifespan Health Services continues to develop pre and inter-conception health strategies. Women who are well informed, have reproductive life plans, and are engaged in taking care of their own health will be more likely to recognize the importance of prenatal care when they do become pregnant, the pregnancies will more likely be intended, and women will more likely seek out prenatal care. They will also be more likely to have better health status as they enter pregnancy, compensating somewhat for a later entry into care should they have difficulty accessing care in the first trimester. These pre and inter-conception strategies have been incorporated into Nebraska's First Time Motherhood/New Parents Initiative Project, now branded as TUNE. To learn about the social media component of the project, go to http://www.tunemylife.org/.

As stated elsewhere in the application/report, Nebraska ended its practice of considering an unborn child as eligible for Medicaid. As a result, a significant number of women previously eligible for Medicaid coverage of their prenatal care no longer are. A Legislative Interim Study on this issue is planned for later this year.

c. Plan for the Coming Year

Work of the First Time Motherhood/New Parents Initiative grant will continue under a no-cost extension. Training resources for health, social service, faith-based and education professionals will be promoted and disseminated through training sessions, conferences, and a web site. The TUNE theme will be used to brand these resources, connecting the social media component with the provider component. Provider resources will include materials such as student lesson plans and Life Course Health Plans (a rebranded reproductive life plan). Contracts will be awarded competitively to community-based organizations to implement preconception health strategies using TUNE resources.

With the completion of the needs assessment, with access to and quality of perinatal health services identified as a priority, purposeful and targeted strategy development will occur. The findings of the Infant Mortality Disparity work group, completed in FY 2009, will provide part of the framework. Yet much analysis and policy level discussion needs to occur around Medicaid eligibility through various venues, such as the Legislative Interim Study.

At the same time, the impact of health care reform on access to prenatal care will need to be carefully studied. Through the public input process for this application/report, one commenter wrote: "Many health care providers have recently taken maternity/labor and delivery coverage off of their standard plans, and are charging extra for this coverage; healthcare providers (such as United Health Care) are also going so far as to state that this coverage was removed as a result of the health care reform bill that passed. In actuality, the decision to remove maternity coverage from standard plans is a reaction to the requirement for all Americans to obtain healthcare coverage and the insurance providers to agree to coverage -- pre-existing health conditions aside (hence the claim that healthcare reform is at fault for this deletion of coverage). In truth, however, providers have opted to cover less due to their own drive to balance the costs and incoming monies...." Though this statement is one person's opinion and observation, it illustrates the range of issues that may impact perinatal health services in Nebraska and elsewhere.

D. State Performance Measures

State Performance Measure 1: *Percent women (18-44) with healthy weight (BMI)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		52.6	53.6	54.2	54.6
Annual Indicator	51.6	49.9	54	53.5	49.4
Numerator					
Denominator					
Data Source				NE BRFSS	NE BRFSS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55.6	56.7	57.9	59	

Notes - 2009
2009 NE BRFSS, weighted data.

Notes - 2008
2008 NE BRFSS, weighted data.

Notes - 2007
2007 NE BRFSS, weighted data.

a. Last Year's Accomplishments
In FY 2007, the Office of Women's Health launched a project funded under the "Innovative Approaches to Promoting a Healthy Weight in Women" initiative. This three year project focuses on community-based interventions in both a rural and an urban settings. In FY 2008, the project was fully implemented and continued on into FY 2009. Evaluation data was collected on the impact on health status and behaviors of women participating in the two sites.

In 2008, the Health Promotion Unit received a grant award from the CDC for Nutrition, Physical

Activity, and Obesity Prevention. This 5-year, $726,953 per year grant is substantively building Nebraska's capacity to develop and support comprehensive nutrition and physical activity efforts, including those for the women of reproductive age. The State Plan details the development and enhancement of supports within communities, schools and child care facilities, worksites and health care systems to improve environments, policies, and social supports for healthy eating and physical activity.

The MCH/CSHCN Strategic Planning Workgroup developed logic models focused on healthy weight among women of reproductive age. These logic models were incorporated into the RFA for community-based MCH projects. Two projects were funded with nutrition and physical activity components addressing women in this age group. Two additional projects address broader goals related to preconception health, but relevant to this performance measure.

Marketing research conducted under the First Time Motherhood/New Parents Initiative grant identified some of the key messages of importance to young women regarding good nutrition, physical activity, and healthy weight. This research informed the development of the TUNE campaign and specific relevant content to promote preconception approaches to healthy weight.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued the "Innovative Approaches to Promoting a Healthy Weight in Women" initiative. This three year project focuses on community-based interventions in both a rural and an urban settings.			X	
2. Health Promotion received a Nutrition, Physical Activity, and Obesity Prevention grant and is building capacity, including that for services for women of reproductive age.				X
3. The MCH/CSHCN Strategic Planning Workgroup developed logic models focused on healthy weight among women of reproductive age.			X	
4. Marketing research conducted under the First Time Motherhood/New Parents Initiative grant identified some of the key messages of importance to young women regarding good nutrition, physical activity, and healthy weight.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Lifespan Health Services continues to collaborate with the Health Promotion Unit in implementing the Nutrition, Physical Activity, and Obesity Prevention grant project. The Innovative Approaches to Healthy Weight in Women Project is soon to conclude and is in the final stages of evaluation. The First Time Motherhood/New Parents Initiative, now branded as TUNE, includes messages for women ages 16 - 25 addressing healthy weight. Life Course Health Plans (a modified reproductive life plan tool) is being developed and will soon be incorporated into training for health care providers. The 4 community-based projects funded in 2008 and 2009 continue.

c. Plan for the Coming Year

With this measure being continued into the next 5 year period, Nebraska Title V will be reassessing state-level strategies to address healthy weight among women. Logic models developed in 2008 will be reviewed for progress in implementing strategies. Areas for which new attention will be given is prenatal weight gain and postpartum weight management.

State Performance Measure 2: *Percent of women of child-bearing age who report smoking in the last 30 days*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	19.3	17.5	21.4	19.1	19.9
Annual Indicator	25.4	21.9	19.5	20.3	17.6
Numerator					
Denominator					
Data Source				NE BRFSS	NE BRFSS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	19.5	19.1	19.7	18.3	

Notes - 2009
2009 NE BRFSS, weighted data.

Notes - 2008
2008 NE BRFSS, weighted data.

Notes - 2007
20067 NE BRFSS, weighted data.

a. Last Year's Accomplishments
As reported under National Performance Measure 15 --

Beginning December 10, 2008 Nebraska Medicaid covered counseling and certain drugs specifically approved to help clients quit using tobacco. In order for a Medicaid client to be eligible to receive Medicaid coverage of the drug product, the client must be at least 18 years of age and must be enrolled and actively participating in the Tobacco Free Quitline. There is a special protocol for pregnant women enrolled in the Medicaid program. Pregnant women do not receive medication, but have unlimited use of the Tobacco Free Quitline, and may access the tobacco cessation counseling visits.

Sixty percent (60%) of all of the calls to the Tobacco Free Quitline receive Medicaid benefits, and the calls to the quit line increased after the above service was implemented. The data from the quit line is analyzed as an aggregate due to HIPAA, so it is unknown how many pregnant women completed the counseling service, but approximately 60% of the total calls to the quit line are women. See Current Activities below.

Overall, 60% of the callers are women, 30% are men, and the remaining callers do not reveal their gender. Between July 1, 2009 and April 30, 2010, nine pregnant women accessed the quitline, and seven breast feeding women accessed the quitline. However as reported earlier, it is unknown if they completed the counseling.

Between July 1, 2009 and December 17, 2009, 56% or 439 callers were between 18-44 years of age, 10.4% of the callers were between 18-24 years of age, 15.3% were between 25-29 years of age, and 31.2% were between 30-34 years of age. As for educational level, 32% of the callers had completed high school or received their GED.

On June 1, 2009, the Clean Indoor Air Act went into effect and Nebraska became the 16th state to require indoor workplaces in Nebraska to be smoke-free. The purpose of the Act is to protect the public health and welfare by prohibiting smoking in public places and places of employment. The Act eliminates smoking in enclosed indoor workspaces including restaurants, bars, keno establishments, other workplaces (retail/office space, manufacturing, etc.) and indoor public places.

Nebraskans overwhelmingly support the law, and a six month report was published in January 2010. See Current Activities below.

More information about this act can be found at: http://smokefree.ne.gov.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nebraska Medicaid covered counseling and certain drugs specifically approved to help clients quit using tobacco.	X		X	
2. Clean Indoor Air Act went into effect and Nebraska became the 16th state to require indoor workplaces in Nebraska to be smoke-free.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

As reported under National Performance Measure 15 --

Tobacco Free Nebraska has recently developed a web site devoted to tobacco cessation. This web site can be found at: http://www.dhhs.ne.gov/tfn/ces

Web coaching services will begin in August. Tobacco users will be able to access counseling via the web if they prefer a web site over the quitline, or quitline users can receive additional counseling services through the web site.

Based on the data collected for the Six Months of Smoke-Free Air report: there is public support for the law; people recognize the importance of the law; the public believes that the law is making work place healthier; the frequency of going to bars, restaurants and gaming establishments is not significantly impacted by the law; for some tobacco users, the law is an impetus to quit smoking; and the full report can be found at: http://smokefree.ne.gov

Lifespan Health Services supports these activities in the Nebraska Tobacco Free Program; staff continues to provide tobacco cessation resource materials to providers at no cost.

c. Plan for the Coming Year

This State Performance Measure will not be continued into the next 5 year period.

As indicated under NPM 15, Nebraska Title V and Tobacco Free Nebraska will continue long-standing collaborations to promote tobacco prevention and cessation within the MCH populations. New initiatives will be developed as resources permit.

State Performance Measure 3: *Percent of women age (18-44) who report mental health not good 10+ days of past 30*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		10.1	13.2	12.9	10.5
Annual Indicator	10.3	13.5	13.1	10.8	14.4
Numerator					
Denominator					
Data Source				NE BRFSS	NE BRFSS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10.3	10.1	9.9	9.7	

Notes - 2009
2009 NE BRFSS, weighted data.

Notes - 2008
2008 weighted data

Notes - 2007
2007 NE BRFSS, weighted data.

a. Last Year's Accomplishments
The work products of the Perinatal Depression Project that were completed during 2007 were maintained. Resources for women and their families include: brochures in English and Spanish; posters in English and Spanish; web site www.dhhs.ne.gov/MomsReachOut; and a traveling exhibit. Provider resources include: web site www.dhhs.ne.gov/Perinatal Depression; interactive curriculum for continuing education for mental health practitioners, nurses and physicians; toolkit; a traveling exhibit; and brochures and posters.

The Women's Health Council formed a task force to examine ways to further advance efforts to improve screening, referral and treatment of perinatal depression.

The First Time Motherhood/New Parents Initiative project yielded information related to stress and social/emotional status of young women ages 16 - 25. The findings of the marketing study were incorporated into a social media campaign that includes an emphasis on social-emotional wellbeing and seeking supports when needed. See http://www.tunemylife.org/ .

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The work products of the Perinatal Depression Project that were completed during 2007 were maintained, including web site			X	X

and provider curriculum.				
2. The Women's Health Council formed a task force to examine ways to further advance efforts to improve screening, referral and treatment of perinatal depression.				X
3. The findings of marketing study were incorporated into TUNE social media campaign that includes an emphasis on social-emotional wellbeing and seeking supports when needed. See http://www.tunemylife.org/ .			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Women's Health Council's task force continues its examination of systems issues surrounding pregnancy related depression. Their work has been focused on Omaha, and through a series of meetings, the task force has raised awareness of gaps in access to needed services, particularly for low income women.

The work products of the Perinatal Depression Project are being sustained, and the TUNE project continues to be rolled out, with provider training underway and community-based contracts soon to be awarded.

c. Plan for the Coming Year
This performance measure will be discontinued beginning in FY 2011.

Though the newly identified priorities do not include women's mental health issues, such as pregnancy related depression, work will be continued because of its relevance to a number and wide range of priority issues, such as abuse and neglect of infants, dispartieis in infant outcomes, and overweight among women.

State Performance Measure 4: *Percent of teens who report use of alcohol in last 30 days*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	45.6	42	41.2	40.1	39.3
Annual Indicator	42.9	42.9	41.1	41.1	31.3
Numerator					
Denominator					
Data Source				NE YRBS	NE YRBS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	38.5	37.7	36.9	36.2	

Notes - 2009
2009 YRBS did not achieve an adequate response rate.

Notes - 2008
2007 YRBS did not achieve an adequate response rate. YRBS is conducted every two years.

Notes - 2007
2007 YRBS did not achieve an adequate response rate.

a. Last Year's Accomplishments
The Adolescent Health Program within Lifespan Health Services continued the work of NE Partnerships for Positive Youth Development through the promotion and advocacy of the principles of positive youth development. A focus was placed on the risk and protective factors associated with underage drinking and other adolescent risk behaviors resulting in negative outcomes for this population. Education was provided to local coalitions, youth serving groups, stakeholders and partners of the important of reducing the risk factors as well as advocating youth development as the foundation for all prevention efforts. Presentations were made to various groups including the state's Family and Consumer Science Teachers as well as those groups focusing on reducing teen pregnancy. Identifying evidence-based practices that incorporate youth development concepts was an outcome of a task force addressing teen pregnancy. Participation continued on the task force working to implement the YRBS, YTS and NRPFSS with the goal of conducting a combined survey effort within school districts in the fall of2010. The second edition of Nebraska Adolescents, Keeping Them Healthy, which highlighted and compared the state's YRBS results and identified risk factors across multiple health issues, was completed and issued through a collaborative effort with the Department of Education.

Nebraska's Strategic Prevention Framework, State Incentive Grant (SPF SIG) issued its strategic plan in March 2008. Three alcohol-related priorities were identified in this plan: 1) Prevent alcoholuse among persons 17 and younger; 2) Reduce binge drinking among 18-25 year olds; and 3)Reduce alcohol impaired driving across all age groups. In 2008, SPF SIG also completed the process of issuing a Request for Applications to fund projects at the community level. Funding source is the federal Substance Abuse Mental Health Services Administration. Selected projects that addressed the three priorities identified by the state continued to be in place among sixteen (16) state organizations during 2009. Applicants were required to incorporate evidence-based strategies as well as address the risk and protective factors associated with alcohol use among adolescents.

SPF SIG developed supportive materials for local projects including an implementation tool kit that assists local grantees to successfully implement their SPF SIG strategic plans. A strategy approval guide was also developed. The guide describes population level behavior change theory, criteria to help determine if a strategy is a good fit for the community, a set of strategies that are pre-approved for SPF SIG communities, and the process for seeking approval of strategies. Nine additional communities were awarded grants for substance abuse prevention activities primarily among school-aged youth. Source of funding for this activity is the Safe & Drug Free Schools Program.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued the work of NE Partnerships for Positive Youth Development through the promotion and advocacy of the principles of positive youth development, including those related to youth drinking behaviors.				X
2. Strategic Prevention Framework, State Incentive Grant (SPF SIG) supported projects in 16 communities addressing youth drinking.			X	X

3. SPF SIG developed supportive materials for local projects including an implementation tool kit that assists local grantees to successfully implement their SPF SIG strategic plans.				X
4. Nine communities awarded grants for substance abuse prevention activities primarily among school-aged youth. Source of funding for this activity is the Safe & Drug Free Schools Program.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Adolescent Health Program launched an Adolescent Comprehensive Systems initiative patterned from the Early Childhood Comprehensive Systems (ECCS) project. Supported by mini-grant funds from AMCHP, stakeholders and staff within the Department were convened to begin identifying the components of a comprehensive system for this population. Education specific to risk and protective factors associated with all risk behaviors and outcomes was provided to numerous groups including the state's Head Start Conference, a tele-health session provided to school nurses and as a roundtable contributor at a statewide Dropout Summit. The Adolescent Health Program is one of several partners collaborating with the Department of Education in launching a Coordinated School Health initiative across the state.

The SPF SIG and Safe & Drug Free Schools programs continue to support community-level alcohol prevention activities.

c. Plan for the Coming Year
This performance measure will be continued into the next 5 year period.

The Adolescent Health Program plans to continue the development and refinement of the Adolescent Comprehensive Systems Initiative on an on-going basis. Strategies for addressing the selected outcomes and indicators will be identified and appropriate action steps put in place. Work groups for each of the identified system components will be recruited and operationalized. The program will continue to collaborate with the SPF SIG activities including the implementation of the Nebraska Youth Risk and Protective Factor Student Survey (NYRPFSS), the Youth Risk Behavior Survey (YRBS) and the Youth Tobacco Survey (YTS). The program will participate in an on-going Coordinated School Health training cadre providing implementation training and instruction to selected school districts across the state.

SPF SIG will carry out action steps in accordance with its strategic plan. Technical assistance as well as tools and materials will be made available to all grant recipients. Special emphasis will be given to assessment, coalition building and effectiveness, evaluation, cultural competency, and sustainability

State Performance Measure 5: *Percent premature births (births<37 weeks)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		8.7	9.8	9.6	9.8

Annual Indicator	9.8	10.0	9.6	9.6	9.7
Numerator	2566	2676	2584	2598	2611
Denominator	26144	26723	26935	26992	26931
Data Source				Birth file	Birth file
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9.3	9.1	8.9	8.8	

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

a. Last Year's Accomplishments
In 2008, the Preterm/Low Birth Weight Work Group completed its review of the literature and data, and then reviewed evidence based interventions for the prevention of preterm/low birthweight. Three logic models were developed, each addressing a range of life course approaches including pre and inter-conception health. These logic models were incorporated into the RFA for community-based MCH projects, issued May 2008. Applications were received the week of July 1, 2008 and awards were made for a 3-year period that began in FFY 2009.

Three of the community-based projects selected through this competitive process in 2008 have as a selected goal the reduction of preterm births/low birth weight. All three are addressing this goal through preconception/inter-conception strategies. These funded projects operated throughout 2009.

A contract was executed with the Douglas County Health Department to develop local capacity to address preconception health as a strategy to reduce rates of preterm birth and infant mortality. This contract also included activities to improve screening and referral for risk factors during pregnancy.

The First Time Motherhood/New Parents Initiative was launched, further building our capacity to impact preconception health within a life course health development model.

The Infant Mortality Disparity work group addressed preterm birth related factors, particularly comprehensive supports for women and access/utilization issues specific to communities.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Three community-based projects addressing goal to reduce of preterm births/low birth through preconception/inter-conception strategies.			X	
2. Douglas County Health Department contracted to develop local capacity to address preconception health as a strategy to reduce rates of preterm birth and infant mortality.				X
3. The Infant Mortality Disparity work group addressed preterm birth related factors, particularly comprehensive supports for women and acess/utilization issues specific to communities.				X
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
Nebraska Title V continued its emphasis on a life course health development model. Year Two of the First Time Motherhood/New Parents Initiative saw the roll out of an informational campaign for young women ages 16-25 (see http://www.tunemylife.org/) , education for provider groups to better promote preconception health, and contracts with selected communities to support life course/preconception health programming.

c. Plan for the Coming Year
This performance measure will not be continued in FY 2011. Work related to this measure will continue, though, because of its relevance to other priorities and measures.

State Performance Measure 6: *Rate of infant death to adolescents (age 15-17)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		7.7	7.5	7.4	7.2
Annual Indicator	8.7	8.1	7.3	8.9	
Numerator	6	5	5	6	
Denominator	690	616	687	671	
Data Source				Linked Birth and Death file	
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7	6.9	6.7	6.6	

Notes - 2009
Data not yet available.

Notes - 2008
Data not yet available.

Notes - 2007
Data not yet available.

a. Last Year's Accomplishments
The Preterm Birth/Low Birth Weight Work Group logic models were incorporated into the RFA for community-based MCH projects issued in 2008. Four of the selected projects incorporate preconception/life course strategies with the potential for positively impacting adolescents and their health behaviors and outcomes. Those projects continued through 2009.

A TANF supported project serving women who are pregnant or believe they are pregnant provided supportive services to women, including adolescents, in one community.

The First Time Motherhood/New Parents Initiative Grant project developed messages targeted to adolescents through young adulthood (ages 16-25).

Title X/Family Planning services continued to be a core program for providing preventive health

services to adolescents.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Four Title V community projects incorporate preconception/life course strategies with the potential for positively impacting adolescents and their health behaviors and outcomes.			X	
2. A TANF supported project serving women who are pregnant or believe they are pregnant provided supportive services to women, including adolescents, in one community.		X		
3. The First Time Motherhood/New Parents Initiative Grant project developed messages targeted to adolescents through young adulthood (ages 16-25).			X	X
4. Title X/Family Planning services continued providing preventive health services to adolescents.	X		X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The four Title V funded community based projects continue to provide preconception/interconception services to women of reproductive age, including adolescents.

The First Time Motherhood/New Parents Initiative Project work products, including TuneMyLife.org, have been completed. The TANF supported project continues. The Adolescent Health program continues to develop a comprehensive systems model for adolescent health, similar to that that has guided the Early Childhood Comprehensive Systems project. This model, when fully developed, will provide an integrated framework to address a range of healthy outcomes for adolescents.

c. Plan for the Coming Year
This measure will not be continued in FY2011. The new priority related to unintended pregnancy and STD's will have similar but re-focused strategies, yet to be developed.

State Performance Measure 7: *Incidence of confirmed SIDS cases (per 1,000 live births) among African American and Native American infants*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	2.5	2.7	2.6	2.3	2.3
Annual Indicator	3.0	2.7	2.4	2.6	2.8
Numerator	29	27	25	28	31
Denominator	9579	9960	10446	10788	11067

Data Source				Death file, Birth file	Death file, Birth file
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.3	2.3	2.3	2.3	

Notes - 2008
2008 Death file is incomplete, missing out of state deaths and few thousand causes of death. Because numbers are so small this is (and has been) a 5 year average.

Notes - 2007
2007 Death file is incomplete, missing out of state deaths and few thousand causes of death. Because numbers are so small this is (and has been) a 5 year average.

a. Last Year's Accomplishments
Through the efforts of Baby Blossoms, an Omaha area collaborative, a vigorous safe sleep campaign has been in place in Douglas County for a number of years. The Douglas County Health Department facilitated efforts that included development of curricula for health care and child care providers, educational materials, and public awareness events. Baby Blossoms continued its focus on this issue in 2009.

The 2006 legislative session yielded a new law with several provisions related to SIDS, sudden infant death, and shaken baby syndrome. LB 994 included provisions requiring: training on SIDS, Shaken Baby Syndrome, and child abuse for licensed child care providers; inclusion of SIDS and Shaken Baby Syndrome information in Learning Begins at Birth, a booklet provided to all new parents through a collaboration of the Nebraska Department of Education and HHSS; hospital provided information to parents of newborns via video and written materials on sudden infant death, shaken baby syndrome, dangers of bed sharing, and other related risks; and a public awareness campaign regarding SIDS and Shaken Baby Syndrome. The Child Care Licensing unit took the lead on the child care training provision, and the Lifespan Health Services Unit, along with Children and Family Services' Child Welfare Unit, took the lead on the other provisions. During FFY 2007, materials were developed and distributed to hospitals, and the Department continued to maintain resources for hospitals and other interested providers through FY 2009.

Reducing rates of infant mortality and eliminating disparities for SIDS and other sudden unexpected infant deaths was included as a goal for the competitive RFA for community-based MCH projects, issued May 2008. Applicants could choose two associated outcomes related to this performance measure: health and human service providers deliver consistent, accurate messages on safe sleep practices for infants; and parents and other caregivers routinely provide safe sleeping environments for infants. None of the applicants specifically addressed the goal or associated outcomes. But a local FIMR project was funded in a rural area of the state, which will provide additional information to address associated risk factors for SIDS and SUID. This is the second local FIMR project in Nebraska, with the other in operation in an urban area (Omaha/Douglas County). Both continued operation in FY 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Baby Blossoms, an Omaha area collaborative, continued a vigorous safe sleep campaign in Douglas County.			X	
2. Maintained resources required under LB994 (training on SIDS for licensed child care providers; inclusion of SIDS booklet			X	X

provided to all new parents, videos and written materials for new parents).				
3. Local FIMR project funded in a rural area of the state, providing additional information to address associated risk factors for SIDS and SUID.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Department continues to maintain and support the provisions of LB 994. Omaha Baby Blossoms continues its educational and informational campaign with partners such as Omaha Healthy Start. Nebraska's Child Death Review Team and the two local FIMR projects continue to identify factors associated with SIDS and SUID.

c. Plan for the Coming Year

This performance measure will not be continued into the next 5 year period. Regardless, factors contributing to disparities in infant health outcomes will be continually monitored, including rates of SIDS and SUID. Ongoing diligence in promoting appropriate institutional practices, continued public education, and development of new partnerships to promote safe sleep will be important to make additional progress in reducing rates of SIDS and SUID.

State Performance Measure 8: *The percent of African American women beginning prenatal care during the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	79.5	69.9	71.3	60.4	55.5
Annual Indicator	68.6	58.8	58.4	54.6	48.9
Numerator	1033	1030	1069	970	964
Denominator	1505	1752	1831	1778	1970
Data Source				Birth file	Birth file
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	56.6	57.7	58.9	60	

Notes - 2007

Out of state resident births are not yet in the data file (1000+ births). Nearly 7% of the data for this PM is missing/unknown.

a. Last Year's Accomplishments

Baby Blossoms and Omaha Healthy Start continued to provide leadership in improving prenatal and preconception care for women, with particular attention to disparities in outcomes experienced by African American women. Title V funds continued to support the Maternal Care project that provides prenatal care services to at-risk women in the Omaha area. In 2009, this project added a preconception health component as a requirement for receiving Title V funds.

The Lifespan Health Services and the Child Death Review Team Coordinator continued to work with Baby Blossoms and the Douglas County Health Department in conducting a FIMR project, which continues to yield information on access issues for at-risk women. Efforts continued to better promote the Healthy Mothers, Healthy Babies help line, incorporating outreach and public awareness messages related to prenatal care. Yet use of the help line has not increased significantly. Consequently, an objective to assess use of the helpline was incorporated into the First Time Motherhood/New Parents Intitiative grant application. The marketing firm included questions on use of 800 phone lines as part of its audience research.

The RFA for community-based MCH projects had a focus on life course approaches, including pre- and inter-conception care. This focus is in accordance with a shift to earlier support of women and their husbands/partners, prior to pregnancy. Women who are engaged in their care and receive supportive health information early will with some degree be more likely to seek prenatal care early when they do become pregnant.

The Infant Mortality Disparity Work Group was formed, and it examined factors associated with higher rates of preterm birth, low birth weight, and infant mortality among African American and Native American women. The work group developed logic models for priority strategies to improve birth outcomes and reduce disparities.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Baby Blossoms and Omaha Healthy Start continued to provide leadership in improving prenatal and preconception care for women, with particular attention to disparities in outcomes experienced by African American women.				X
2. Title V funds continued to support the Maternal Care project that provides prenatal care services to at-risk women in the Omaha area. In 2009, this project added a preconception health component as a requirement for receiving Title V funds.	X			
3. Continued to work with Baby Blossoms and the Douglas County Health Department in conducting a FIMR project, which continues to yield information on access issues for at-risk women.				
4. Efforts continued to better promote the Healthy Mothers, Healthy Babies help line, incorporating outreach and public awareness messages related to prenatal care.			X	
5. The Infant Mortality Disparity Work Group was formed, and it examined factors associated with higher rates of preterm birth, low birth weight, and infant mortality among African American and Native American women.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Lifespan Health Services continues to work with its partners, including Douglas County Health Department, Baby Blossoms, and Omaha Healthy Start on collaborative interventions to improve access to quality prenatal care. The TUNE project has been launched, and still planned for later

this year are additional music videos and tailored messages for diverse audiences, including African American women.

c. Plan for the Coming Year
This measure will not be continued into the next 5 year period, but disparities in access to quality perinatal health services will be continually monitored.

Development and implementation of strategies identified by the Infant Mortality Disparity work group will proceed during FY 2011. The Office of Health Disparities and Health Equity will be a major partner in these efforts.

The logic models for the identified strategies reflect a socio-ecological model and emphasize system level responses and community-specific solutions. Building capacity to lead population-based health equity initiatives and support for community-based participatory research are among the intended activities.

Beginning yet this FY, targeted investments in these strategies will be made, based not only the logic models developed in 2009, but the capacity assessment conducted as part of the 2010 Comprehensive MCH/CSHCN Needs Assessment.

State Performance Measure 9: *Hospitalization for unintentional injuries (per 1,000) for children and adolescents*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		110.4	110.2	109.8	129.3
Annual Indicator	117.5	118.6	129.8	125.9	
Numerator	55225	55890	61254	60413	
Denominator	469913	471382	471930	479918	
Data Source				Hospital Discharge, Census data	
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	124.7	122.3	119.8	117.4	

Notes - 2009
HDD will be available in October 2010.

Notes - 2008
HDD will be available in October 2009.

Notes - 2007
HDD will be available in October 2008.

a. Last Year's Accomplishments
The childhood fall prevention program has been successful at distributing safety devices and educating parents on the dangers of childhood falls. In 2008, Safe Kids Nebraska awarded mini-

grants to programs focusing on the following areas: development, fall prevention, and fire safety. This allowed Safe Kids coordinators to expand their efforts to address new risk areas. These mini-grants gave programs opportunities to reach high-risk population that are often left out of mainstream programming. A higher level of funding for mini-grants was awarded in 2009. Safe Kids Nebraska awarded six grants to local Safe Kids programs and local health departments. These projects addressed fall prevention, bike and wheeled sports safety, and fire and burn prevention. The Safe Kids Nebraska program initiated a "Childhood Injury Report." With allocated funds from the Preventive Health and Human Services Block Grant, this report helped further assess and evaluate current programming across the state.

The Child Death Review Team continued its work to assess preventable child deaths, including unintentional injuries. The Child Death Review Team noted trends in house fires impacting some populations, and the coordinator initiated conversations with the State Fire Marshall on possible strategies.

The State Title V/MCH Director worked with the Injury Prevention Program to prepare an application for CDC funding to build capacity in the area of childhood injury prevention. The application was not funded.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Safe Kids Nebraska awarded mini-grants to programs focusing on the following areas: development, fall prevention, and fire safety.			X	X
2. The Safe Kids Nebraska program initiated a "Childhood Injury Report." This report helped further assess and evaluate current programming across the state.				X
3. The Child Death Review Team assessed preventable child deaths, including unintentional injuries. Noted trends in house fires impacting some populations; initiated conversations with State Fire Marshall on possible strategies.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Injury Prevention Program continues efforts in fall prevention. A Playground Safety Workshop was conducted in May, 2010. Approximately 50 participants attended the workshop which was presented by the National Program for Playground Safety. Participants, who came from a variety of communities and agencies from around the state, will utilize the information in assessing and modifying playgrounds which will help to reduce fall-related injuries.

c. Plan for the Coming Year

This performance measure will not be continued into the next 5 year period.

Collaborations with Safe Kids Nebraska will continue, and the Child Death Review Team will have ongoing responsibility to review deaths due to unintentional injuries and to make recommendations for prevention of such injuries.

State Performance Measure 10: *Hospitalization for intentional injuries (per 1,000) for children and adolescents (age 1-19)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		5	4.9	4.8	3.8
Annual Indicator	3.9	4.1	3.9	3.9	
Numerator	1835	1917	1862	1884	
Denominator	469913	471382	471930	479918	
Data Source				Hospital Discharge, Census data	
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3.7	3.7	3.6	3.5	

Notes - 2009
HDD will be available in October 2010.

Notes - 2008
HDD will be available in October 2009.

Notes - 2007
HDD will be available in October, 2008.

a. Last Year's Accomplishments
During 2006 LB 994 was passed, which included several provisions related to prevention and early detection/intervention of child abuse with a specific emphasis on shaken baby syndrome. Provisions included training requirements for licensed child care providers, inclusion of information in packet provided to newborn parents by HHSS/NE Dept. of Education titled "First Connections with Families - Learning Begins at Birth," parents viewing a video and written materials in health facilities prior to discharge of a newborn, and a public awareness campaign. Child Care Licensing, Lifespan Health Services, Child Welfare, and Communications staff of DHHS worked on various aspects of these requirements. In addition, the Nebraska Children's and Families Foundation lead an effort to develop and promote training and awareness of child abuse prevention/detection/referral among a wide range of early childhood care and education providers. These activities, begun in 2006, continued through FFY 2009.

The Title V/MCH Director actively participated in the Prevention Partnership, coordinated by the Children and Families Foundation. The Partnership focused on promoting evidence based practices during 2009.

The appropriations bill passed by the Legislature and signed by the Governor included $600,000 per year for SFYs 2008 and 2009 to expand home visitation as a child abuse and neglect prevention and early intervention strategy. Lifespan Health Services contributed to the development of a Request for Bids for these home visitation services. Contractors were selected, with these contracts supported with State General Funds and administered by the Division of Children and Family Services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued to maintain materials and resources developed under LB994 (training for child care providers, information packets, videos for new parents).			X	
2. Participated in the Prevention Partnership, coordinated by the Children and Families Foundation. The Partnership focused on promoting evidence based practices during 2009.				X
3. State appropriation of $600,000 per year expanded home visitation as a child abuse/neglect prevention & early intervention strategy. Service contracts administered by the Division of Children and Family Services.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The work of the Prevention Partnership continues, with an emphasis now on developing community-capacity to promote child well being using a comprehensive, socio-ecological approach. Deb Daro was a recent speaker at a Partnership event, bringing together community providers and state level stakeholders to develop these comprehensive approaches.

The Department continues to support hospitals and child care providers in carrying out the abuse and neglect prevention provisions of LB 994.

c. Plan for the Coming Year

This measure will not be continued into the next 5 year period. A new state performance measure will be in place to address rates of substantiated reports of child abuse and neglects.

Nebraska Title V will work within the Prevention Partnership framework to develop more targeted strategies to address abuse and neglect specifically among infants and CSHCN since these populations were identified as the priority. Identifying and/or developing data sources specific to CSHCN will be among the challenges for addressing this issue.

E. Health Status Indicators

Introduction

Brief narratives are provided for each of the indicators. Details of activities are found elsewhere in this application.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.0	7.1	7.0	7.1	7.1
Numerator	1793	1910	1894	1909	1923
Denominator	25751	26723	26925	26989	26930
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

Narrative:
Low weight birth rates in Nebraska declined throughout the 1970s and 1980s, before reversing direction in the 1990s and during the present decade. Long-term trends show that Nebraska's annual low birth weight rate has increased steadily since falling to an all time low of 5.28 in 1990, and is now holding steady. Nebraska has experienced increasing numbers of multiple births in recent years, which is one contributing factor.

Prematurity/low birth weight had been a priority for the 5 year period of 2005-2010. A work group that developed strategic direction to address the issue of prematurity focused on preconception health. Consequently, Nebraska Title V investments have been expanded in this area since 2008-2009.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	5.2	5.4	5.2	5.3	5.4
Numerator	1302	1388	1335	1391	1394
Denominator	24889	25807	25912	26050	25929
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

Narrative:
As stated under HIS 01A, Nebraska Title V investments have been expanded in the area of preconception health and will be maintained. Going forward, additional analyses and attention to factors such as non-medically indicated inductions and C-sections will occur, and strategies to

address findings will be developed as indicated, since this indicator continues to increase (worsen).

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.2	1.2	1.3	1.2	1.2
Numerator	311	333	350	326	318
Denominator	25751	26723	26925	26989	26930
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

Narrative:
For many years, Nebraska's annual very low birth weight rate showed no consistent trend in any direction, but between 1986 and 1996, it rose by about 50%, and has changed little since.

Baby Blossoms, an Omaha based coalition, has analyzed infant/fetal mortality by gestational age and birth weight, using the Perinatal Periods of Risk (PPOR) model. Though PPOR is difficult to apply with state level data, the Omaha findings and the PPOR model are useful in informing strategies. Very low birth weight and associated deaths can best be prevented by improving maternal health and addressing prematurity. As stated for earlier HSIs, Nebraska Title V investments in preconception health will be maintained, and additional work will proceed in better understanding other factors associated with premature birth.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.9	0.9	0.9	0.9	0.9
Numerator	216	241	237	236	226
Denominator	24889	25807	25912	26050	25929
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:

See narrative for Health Status Indicator 02A.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.6	8.5	6.7	7.9	5.4
Numerator	29	29	23	27	19
Denominator	338806	339983	341855	343908	349420
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
2007 Death file is incomplete, missing out of state deaths and few thousand causes of death.

Narrative:
Nebraska Title V investments in prevention of deaths due to unintentional injuries have been focused on those associated with SUID and infant sleep environments. Safe Sleep resources will be maintained, and collaborations to enhance prevention strategies will be continued. The Nebraska Safe Kids Program has primary responsibility for childhood injury prevention, and Nebraska Title V will continue to collaborate with this program.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.3	3.8	4.1	1.7	3.4
Numerator	18	13	14	6	12
Denominator	338806	339983	341855	343908	349420
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
2007 Death file is incomplete, missing out of state deaths and few thousand causes of death.

Narrative:
The Nebraska Safe Kids Program has a well established, ongoing program to address motor vehicle safety for children, particularly proper use of restraints. Since 2002, child passenger restraint laws have been expanded twice, passengers in cargo area of pickup were prohibited for

persons thru age 17, and penalties for repeat DUI offenders were enhanced twice. Concurrently, there has been a general decline in fatal crashes and fatalities since 2002. The uptick in 2009 fatalities among children will be tracked for trends.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	27.0	30.4	29.5	24.8	22.1
Numerator	73	81	78	65	60
Denominator	270686	266705	264334	262190	271201
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
2007 Death file is incomplete, missing out of state deaths and few thousand causes of death.

Narrative:
Injury crash rates have steadily declined since 1995, from 114 per 100 million vehicle miles to 58 in 2009. Traffic fatalities and fatal crashes have generally declined since 2002. Motor vehicle safety laws of particular relevance to youth ages 15 -- 24 have been passed during these periods: a zero tolerance for blood alcohol for drivers under 21 (1994), graduated licensing law (1999), expanded child passenger restraint law through age 17 (2004), learner's and school permit laws enhanced (2008), and underage "dram shop" law (2008). Collectively, these policy level strategies may be a factor in the continual deline (improvement) in this measure.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	262.7	279.7	267.1	265.9	
Numerator	890	951	913	929	
Denominator	338806	339983	341855	349420	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
HDD will be available in October 2010.

Notes - 2008
2008 HDD data is released in October of 2009.

Notes - 2007
2007 HDD data is not available until October, 2008.

Narrative:
The leading causes of unintentional injuries to children 14 and under are traffic incidents (including children as occupants, pedestrians, and bicyclists), fire and burns, drownings and near drownings, fall, poisonings, choking/suffocation/strangulation, and sports and recreation injury. Nebraska's Safe Kids program has had a primary emphasis on motor vehicle injuries over the years, but has increased its capacity to analyze other causes and is in a better position to plan population-based primary prevention efforts. See http://www.dhhs.ne.gov/hew/hpe/Injury/facts.htm.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	19.5	9.7	16.7	9.7	
Numerator	66	33	57	34	
Denominator	338806	339983	341855	349420	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
HDD will be available in October 2010.

Notes - 2008
2008 HDD data is released in October of 2009.

Notes - 2007
2007 HDD data is not available until October, 2008.

Narrative:
See narrative for HSI 03B.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Indicator	75.0	63.0	68.3	69.7	
Numerator	203	168	179	189	
Denominator	270686	266705	262190	271201	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
HDD will be available in October 2010.

Notes - 2008
2008 HDD data is released in October of 2009.

Notes - 2007
2007 HDD data is not available until October, 2008.

Narrative:
See narrative for HIS 03C.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	21.0	23.6	21.9	24.7	21.5
Numerator	1340	1494	1386	1548	1374
Denominator	63809	63225	63223	62618	63873
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
Rates of Chlamydia and other STDs were of such significance and concern that STDs among women, including adolescents, has been added as a priority for the upcoming 5 year period. Both the Nebraska STD Program and the Reproductive Health Program carry out screening and treatment activities, but additional strategies, particularly at the community level will be essential. Nebraska DHHS, in its application for Evidence Based-Teen Pregnancy Prevention funds, chose Safer Sex, a model that has shown effectiveness in reducing risk factors for STDs. Nebraska will continue to work with stakeholders to identify and implement other strategies as well.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.1	8.1	7.9	8.6	8.5
Numerator	2163	2374	2296	2465	2441
Denominator	302777	292794	290046	285519	288835
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
See narrative for HSI 05A.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	28791	24932	2230	670	897	62	0	0
Children 1 through 4	110863	93685	9667	3658	3521	332	0	0
Children 5 through 9	128774	111962	9808	3026	3689	289	0	0
Children 10 through 14	121251	106540	8956	2448	3050	257	0	0
Children 15 through 19	133346	118426	9097	2599	2928	296	0	0
Children 20 through 24	142960	128324	8422	2578	3248	388	0	0
Children 0 through 24	665985	583869	48180	14979	17333	1624	0	0

Notes - 2011

Narrative:
Narrative not appliable to this HSI on demographics.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY	**Total NOT Hispanic**	**Total Hispanic**	**Ethnicity Not**

TOTAL POPULATION BY HISPANIC ETHNICITY	**or Latino**	**or Latino**	**Reported**
Infants 0 to 1	24096	4695	0
Children 1 through 4	91854	19009	0
Children 5 through 9	109861	18913	0
Children 10 through 14	106506	14745	0
Children 15 through 19	120174	13172	0
Children 20 through 24	130665	12295	0
Children 0 through 24	583156	82829	0

Notes - 2011

Narrative:
For Nebraskans ages 0 through 24, over 12 per cent are Hispanic/Latino.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	25	5	7	2	1	0	0	10
Women 15 through 17	633	340	84	29	8	0	0	172
Women 18 through 19	1578	990	207	50	18	0	0	313
Women 20 through 34	21621	16822	1355	355	519	0	0	2570
Women 35 or older	3074	2391	137	34	152	0	0	360
Women of all ages	26931	20548	1790	470	698	0	0	3425

Notes - 2011

Narrative:
No narrative provided for this demographic HSI.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	15	10	0
Women 15 through 17	419	241	0
Women 18 through 19	1183	395	0

Women 20 through 34	18401	3215	5
Women 35 or older	2640	430	4
Women of all ages	22658	4291	9

Notes - 2011

Narrative:
No narrative provided for this demographic HSI.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	146	113	30	2	1	0	0	0
Children 1 through 4	38	29	6	3	0	0	0	0
Children 5 through 9	12	10	1	1	0	0	0	0
Children 10 through 14	21	19	2	0	0	0	0	0
Children 15 through 19	75	59	11	4	1	0	0	0
Children 20 through 24	102	81	14	5	2	0	0	0
Children 0 through 24	394	311	64	15	4	0	0	0

Notes - 2011

Narrative:
In its last report, the Child Death Review Team points out that death rates per 100,000 children are signficaantly higher for African-American, American Indian, and Hispanic children. In recent years, some causes of these disparities have received focused attention, such as SIDS, SUID, and prematurity/LBW. As Nebraska focuses on new priorities, such as abuse/neglect among infants and CSHCN and disparities impacting infant outcomes, these trends and proximal causes will be further analyzed and strategies developed.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	140	6	0
Children 1 through 4	37	1	0
Children 5 through 9	12	0	0

Children 10 through 14	20	1	0
Children 15 through 19	74	1	0
Children 20 through 24	98	4	0
Children 0 through 24	381	13	0

Notes - 2011

Narrative:
No narrative provided for this demographic HSI.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	523025	455545	39758	12401	14085	1236	0	0	2009
Percent in household headed by single parent	24.1	0.0	0.0	0.0	0.0	0.0	0.0	24.1	2008
Percent in TANF (Grant) families	99.9	38.1	27.4	6.0	1.9	0.2	1.5	24.8	2009
Number enrolled in Medicaid	142621	100067	23259	6238	2492	183	1674	8708	2009
Number enrolled in SCHIP	37447	29279	4312	953	685	36	328	1854	2009
Number living in foster home care	4134	2426	859	203	31	1	136	478	2009
Number enrolled in food stamp program	82326	45279	15202	3472	1194	95	1153	15931	2009
Number enrolled in WIC	56806	35778	6642	9596	741	151	0	3898	2009
Rate (per 100,000) of juvenile crime arrests	3001.9	2709.7	7115.5	3209.4	347.9	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	1.5	1.1	3.8	3.2	1.2	0.0	0.0	0.0	2009

Notes - 2011
No source of data

Narrative:
Of particular note are disparate rates of crime and high school drop out rates. As State MCH programs adopt and adapt life course health models, new partnerships and strategies have to be explored to address these diparaties. Among the initiatives recently developed in Nebraska is a Child Well Being project carried out by the NE Children and Families Foundation. This project involves 5 communities exploring inter-related outcomes and risk-factors and subsequently developing coordinated community responses. At the state-level, currently under development is a Adolescent Comprehensive Systems project, modeled after ECCS.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	452491	70534	0	2009
Percent in household headed by single parent	0.0	0.0	24.1	2008
Percent in TANF (Grant) families	18.3	23.1	58.6	2009
Number enrolled in Medicaid	133967	35649	8654	2009
Number enrolled in SCHIP	35623	10556	1854	2009
Number living in foster home care	2826	643	665	2009
Number enrolled in food stamp program	17945	15086	49295	2009
Number enrolled in WIC	37088	19716	2	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	3001.9	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	3.3	0.0	2009

Notes - 2011
No source of data

Data is not collected by ethnicity

Narrative:
See narrative for HSI 09A.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**
Living in metropolitan areas	270984
Living in urban areas	395096

Living in rural areas	82113
Living in frontier areas	45816
Total - all children 0 through 19	523025

Notes - 2011

Narrative:
This HSI illustrates the concentration of children in a few communities. Rural and frontier areas represent the bulk of Nebraska's geography, yet a small percentage of its children. Assuring access over large expanses has and continues to be a challenge for Nebraska.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1174000.0
Percent Below: 50% of poverty	6.4
100% of poverty	9.5
200% of poverty	27.0

Notes - 2011

Narrative:
These numbers will likely increase for 2009 and 2010, as Nebraska experiences the same national impacts of a recession. Anecdotal reports of increased utilization of food banks and other emergency services portends that the needs of low income Nebraskans are increasing. For the first time, the impact of poverty and food insecurity has been identified as a Nebraska MCH/CSHCN priority. System level strategies will be challenging and new partnerships necessary.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	496000.0
Percent Below: 50% of poverty	7.0
100% of poverty	8.8
200% of poverty	21.3

Notes - 2011

Narrative:
Poverty levels are higher among children, thus accentuating the issues described in HSI 11.

F. Other Program Activities

Healthy Mothers, Healthy Babies Helpline:
The Perinatal, Child and Adolescent Health (PCAH) Program, within Lifespan Health Services, continues to contract with Nebraska Methodist Hospital to provide the Healthy Mothers/Healthy Babies Helpline, Nebraska's toll-free telephone line, as required by statute. The PCAH Program Manager is the state-level contact person for the helpline. The HMHB Helpline provides 24-hour nurse-operator service to the MCH population statewide regarding health care questions, and information and referral for the following: Title V and Title XIX providers, Kids Connection, newborn screening disorder-specific information, and folic acid supplementation. Monthly call report data are tracked and analyzed in order to guide publicity efforts. When the line first began in 1992, calls averaged 7 per month. Call frequency peaked at 880 in FY 2000 with a steady decrease to 415 for FY 2004.

Subsequently, efforts were made to promote the HMHB help line. In 2007, brochures, posters, and magnets were redesigned. Brochures were made available in English and Spanish. Sample materials were sent to over 2,300 Nebraska physicians, nurses, health departments, and agencies to promote the helpline. Other promotion efforts included a HMHB webpage and a presentation to WIC agency directors. The HMHB helpline number is listed in the community service pages of local telephone books, and an ad was placed in the Journal-Start Baby Steps publication which reaches families in southeastern Nebraska. The helpline was also promoted through the Nebraska Perinatal Depression Project website, brochures, posters, and exhibit.

Despite these efforts, he HMHB line received only 412 calls during FFY08. As a result of the continued low usage, the marketing contractor for the First Time Motherhood/New Parents Initiative was asked to assess perceptions of young women in regards to toll-free numbers for accessing health information. Among the findings are that such numbers are no longer "toll free" for persons using cell phones with limited minute contracts. For this reason as well as greater reliance on new technologies, the Internet is becoming the more trusted source of assistance.

During 2010, the Douglas County Health Department became an outreach partner for Text4Babies. With many of the text messages including the national toll-free line and subsequent connection to Nebraska's line, we might expect an increase in usage since Douglas County includes Omaha, Nebraska's largest city. Yet initial reports from the help line contractor indicate that increases have not been significant. We will continue to monitor usage and continue research into the best ways to provide accessible information to a new generation of mothers and fathers.

MCH and Public Health Infrastructure Development:
In many ways, Title V staff contributes to Nebraska's public health infrastructure. The Title V Grants Administrator has taken on an increasingly significant role in the Department level grants management activities, such as developing consistent subgranting tools and methodologies, arranging for agency-wide training and technical assistance, and participating in a risk management committee. The MCH Epidemiology Surveillance Coordinator (Nebraska's SSDI Director) has helped staff Nebraska's Healthy People 2020 project and participates in the agency's data committee.

Health Disparities:
The Office of Health Disparities and Health Equity (OHD&HE) provides leadership for a number of initiatives. The Office of Women's and Men's Health and its Women's Health Council has been working with OHD&HE to conduct a series of community viewings of "Unequal Treatment" later this summer. This activity is seen as essential to increase awareness of health equity issues and will further efforts to move policies and programs towards a life course model that recognizes the additive effects of factors such as stress and racism. With Title V support, OHD&HE is planning additional initiatives for 2011.

New Opportunities:
The ACA appropriated funds for a number of MCH related activities. With thoughtful planning

and coordination, these new sources of financial support can have an impact in building new systems capability. In particular, aligning the ACA Home Visiting Program with the Early Childhood Comprehensive Systems project will lead to greater capacity to impact early childhood outcomes. At the same time, should Nebraska apply for and receive funds for Supports for Pregnant and Parenting Teens and Women, even more of an interconnected system can be built. We are eagerly awaiting guidance for the Personal Responsibility Education funds, as this resource will allow us to make similar investments in building a system for adolescent health and wellbeing.

G. Technical Assistance

In many ways, Nebraska is very fortunate to have many local resources for technical assistance and training available to its Title V supported programs. These include a College of Public Health, the Great Plains Public Health Leadership Institute, CityMatCH, Munroe Meyer Institute (a LEND program), University of Nebraska Public Policy Center, and many other colleges and programs within the University system.

At the regional and national level, Nebraska has a long standing relationship with the MCH Program at the University of Chicago -- Illinois, and had 3 staff recently complete its MCH leadership coaching program. AMCHP has provided active support for our adolescent comprehensive systems development project.

Finally, through partnerships with other Nebraska organizations, such as the PTI Family to Family Program and Boys Town Center for Child Health Improvement, Nebraska Title V has gained information and expertise through participation in their technical assistance and development projects.

The needs for which Nebraska Title V would request MCHB assistance are therefore those specific to the management of the Block Grant. For FFY 2011, Nebraska specifically requests technical assistance in budgeting for and reporting activities in accordance with Block Grant statutory requirements and within the framework of the Guidance and Forms for the Title V Application/Annual Report while at the same time moving towards a life course health model and a social determinants framework.

This model and framework, by their nature, emphasize serving populations in ways that are not rigidly tied to the categories established under Title V. In addition, an emphasis on system level activities and less on distinct services to individuals renders reporting requirements to be problematic, and earmarks difficult to interpret and measure.

In many ways, this request is less for technical assistance but a cooperative relationship to determine ways to operate within a Title V framework that dates back to the 1980's but move public health, including MCH/CSHCN, into new approaches into the next decade and beyond.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	4012760	3661476	4024746		4024332	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	2761046	3407775	2863000		2933000	
4. Local MCH Funds *(Line4, Form 2)*	345000	539827	389515		482266	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	7118806	7609078	7277261		7439598	
8. Other Federal Funds *(Line10, Form 2)*	122175824	0	169056259		136673763	
9. Total *(Line11, Form 2)*	129294630	7609078	176333520		144113361	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	313019	856974	577197		728964	
b. Infants < 1 year old	668929	690498	663817		622881	

c. Children 1 to 22 years old	2030365	1477034	1970630		1965238	
d. Children with Special Healthcare Needs	3081143	3475299	3014817		3067215	
e. Others	861894	945920	890998		891014	
f. Administration	163456	163353	159802		164286	
g. SUBTOTAL	7118806	7609078	7277261		7439598	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	99954		99954		99954	
c. CISS	0		0		0	
d. Abstinence Education	0		0		218740	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	29602585		32904895		34195833	
h. AIDS	0		0		0	
i. CDC	6649579		9356733		8143638	
j. Education	0		0		0	
k. Other						
see note	0		126694677		94015598	
see notes	85823706		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	2465526	2003571	2032153		1931935	
II. Enabling Services	1732862	2099692	1954417		2019842	
III. Population-Based Services	1337721	1897798	2024329		1828530	
IV. Infrastructure Building Services	1582697	1608017	1266362		1659291	
V. Federal-State Title V Block Grant Partnership Total	7118806	7609078	7277261		7439598	

A. Expenditures

This first paragraph is intended as an overview of Section V which Nebraska considers to be more aptly referred to as the Financial Narrative, that should be first followed by budget narrative and subsequently expenditure narrative. Nebraska has longstanding concerns with the budget and expenditure forms and instructions. Subsequently, the narratives in Sections V. A & V. B have remained much the same for a number of years. While we believe there are a number of problems, as detailed throughout the entire Section V., the crux is that the annual reporting requirements are incongruent to the two-year spending authority provided to states and territories. This is complicated to explain, but critical to understand the burden and limited utility of the reported expenditures, and the budget which precedes it. For that reason, the reader is

urged to review Section V. B. Budget prior to and in concert with Section V. A. Expenditures.

Our concerns stem from incongruent requirements of an annual report for a grant with a two-year period of availability of funds, i.e. the federal MCH allotment allows expenditures in the fiscal year or the succeeding one, i.e. a two-year period (42 U.S.C. 703(b)).
Our longstanding concerns were heightened for FY 2000 and FY 2001. Audits of those years resulted in findings that Nebraska was not in compliance with the statutory earmarking requirements due to the method of reporting. The corrective action plan to resolve the finding was an extensive commitment of Title V administrative staff time, in consultation with a respected authority on federal policies affecting acquisition, administration and audit of federal grants. Despite our best efforts to clarify and communicate concerns over time, to-date we believe these attempts have failed to be understood. Our purpose has always been two-fold: 1) to achieve audit resolution for Nebraska to prevent future questioned costs that could result in paying back federal funds, and 2) to improve the utility of the information while minimizing the reporting burden to ALL states and territories. In an effort to reach both goals, we submitted written comments and recommended changes to federal entities involved in the review, revisions, and re-approval of the Guidance and Forms in May 2003 and again in May 2006. Unfortunately, no significant revisions were made to the financial portion of the Guidance and Forms either time. As a result, this narrative attempts to again clarify the limitations of the financial forms, as much to justify expenditures of Nebraska's Title V funds in the FY 2009 report. No resolution of this incongruency forces us to continue using the interpretation to report expenditures "during" the reporting year (12-month period) which for us is from two different federal allotments. Our preference is to report the expenditures of the allotment (up to 24-month period) to coincide with the earmarking requirement. Using the example for the current reporting year, the expenditures of funds "during" FY 2009 is the carryover resulting from unliquidated obligations of the FY 2008 allotment plus expenditures of the FY 2009 allotment through March 2010. Technically, states and territories could continue to expend the FY 2009 funds through September 30, 2010 if not for the annual reporting requirement.
The instructions for the annual report's financial forms are vague and contradictory. Form 3 instructions state: "columns labeled *expended* are to contain the actual amounts expended for the *applicable year*." (Emphasis added). "Applicable year" is not defined in the Glossary. Form 3 feeds into sequentially numbered forms, even further confusing the instructions for Form 4 and Form 5, stated: "enter the budgeted and expended amounts for the appropriate *fiscal year*." (Emphasis added). "Fiscal Year" is not defined either, although is generally understood to mean a 12-month period for accounting purposes. "Fiscal Year", however, could mean an annual allotment with the caveat that for the block grant this is a two-year period of availability of the funds. Without clear guidance, Nebraska has opted to report expenditures "during" FY 2009, a combination of the FY 2008 and FY 2009 allotments.
Section 506(a)(1) of Title V, Social Security Act [42 U.S.C. 706] states generally the requirement for submitting an annual report. Section 506(a)(3)(E)(b)(1) states that expenditures from amounts received under Title V are to be audited not less than once every two years. The two-year audit period may have been intended to coincide with the period of availability of funds for the federal allotment. Financial forms re-approved in May 2009 for the Block Grant Guidance & Forms, as part of the required annual report, are not designed for an audit of the two-year period in which an allotment can be expended. This audit limitation is especially critical for the earmarking requirement established in statute. To further confuse the requirement, the terms "payment" and "allotment" are used interchangeably in statute. [Section 705(a)]. Taken together, the provisions for earmarking and the period of availability of funds make a convincing case that the earmark must be met over the period for availability of funds, not over the single fiscal year in which funds are expended. Our financial reporting in the FY 2009 Report, as in prior years, conforms to the required annual report format showing funds expended "during" a fiscal year.
The corrective action plan to resolve the audit finding was to keep two separate record keeping systems, one for the required annual report based on fiscal year payments and another by expenditures of the allotment. It is inefficient, potentially inaccurate, and burdensome to comply with both the annual reporting requirement and a separate accounting for earmarking on the two-year allotment. Separate record keeping would be unnecessary if the annual reporting forms were

revised to reflect the two-year expenditure of an allotment by subcategories of "Types of Individuals" and "Types of Services".

We have formally submitted comments in the past and continue to urge that these data elements be reduced to the absolute minimum needed to allow for compliance with the statute authorizing the MCH Block Grant, i.e. the earmarked 30-30-10. Further, we have suggested that the fiscal data required by Section 706(a)(2)(iv) be combined with the requirement and timing for submission of the reporting required under 45 C.F.R. 96.30(b), i.e. OMB Standard Form 269A "Financial Status Report" (FSR). This would enhance the ability of all states and territories to reconcile periodic financial reports submitted to the federal government with their annual financial statements audited pursuant to OMB Circular A-133. Further, it would create the ability to demonstrate states' and territories' current carry-over authority available under Section 703(b) of the statute.

Until we began to maintain the additional record keeping by allotment, the auditors looked to the annual report (Form 4) to test for compliance with the earmarking requirement. Form 4 has two limitations to use it for auditing compliance: 1) expenditures are based on the fiscal year (not the expenditures of an allotment); and, 2) the expenditure column of Form 4 "Types of Individuals" combines the federal expenditures with expenditures of State match ("federal-state partnership"). Earmarking compliance is exclusively on the expenditures of the federal allotment. 42 U.S.C. 706(a)(2)(iv). (See also, Legislative Briefing Title V Law Legal Compendium, New MCH State Leaders' Orientation Manual, October 2000, pg. 19). In other words, Form 4 does not identify earmarked expenditures because it is a combination of federal and state funds, nor does it make the necessary distinction between expenditure of an allotment and expenditures in a fiscal year. The FSR reflects the obligations and expenditures for the period of availability of funds, although the format does not incorporate the requirement to categorize expenditures by "Types of Individuals" (Form 4), nor "Types of Services" (Form 5), as required by U.S.C. 706(a)(2)(iv). The non-final FSR (due 15 months into and 9 months prior to the conclusion of the period of availability of funds for an allotment) seeks obligation of unexpended funds for carry-over authority. The FSR is critical to the Form 2 budget and subsequently the remainder of the financial forms that Form 2 drives.

Budget-to-expenditure variations (Forms 3, 4, and 5) cannot be explained without discussing Form 2, albeit a budget form in a section to explain expenditures. Specifically, Line 2, Form 2 "unobligated balance" is problematic due to misinterpretation of several lines of the FSR, i.e. "unobligated balance" and "unliquidated obligations," which are similar phrases, but with a distinct difference for budgeting. The FSR seeks the "unliquidated obligations," i.e. obligated funds not yet expended. In a non-final FSR, Nebraska calculates "unliquidated obligations" as allotment minus outlay. In the final FSR, the same line must be zero. It is acknowledged in the Block Grant Guidance & Forms, page 55, that some definitions have been assigned new meanings for MCHB purposes, i.e. overriding the standard instruction for Standard Form 424, Line 15b. On page 63, the projected funding on the "Applicant" line instructs applicants to report the "unobligated balance" on MCHB Form 1 using OMB's standard form 424. Unfortunately, that figure feeds Line 2 on Form 2. If Form 2 sought the "unliquidated obligations" (obligated, unexpended funds) rather than the "unobligated balance", the budget would accurately reflect the new allotment plus the carryover from the previous allotment. Accordingly, the definition for "carryover" in the glossary would be revised with the correct distinction between "unobligated balance" and "unliquidated obligations". Nebraska reports zero "unobligated balance" because the funds are fully obligated each allotment, so our budget in Form 2 reflects only the new allotment. The difference is typically six figures. Nebraska exercises carry-over authority, although is unable to budget carry-over using the present forms and instructions. Subsequently, it appears that our grant expenditures exceed budget. A wide variance between budget and expenditures, as with previous years, is explained primarily by the incompatible budget and expenditure reporting formats originating with the misinterpretation of the FSR, which feeds Form 2, Form 3, Form 4, and Form 5.

Form 4 requires that administrative costs be reported along with categories of "Types of Individuals". The staff responsible for the administration of Nebraska's MCH Block Grant do not provide services, although administrative costs must be reported among "Types of Individuals Served." Including administrative costs with expenditures for services detracts from the percentage for 30-30 earmarked expenditures, and could contribute to auditing irregularities.

Administrative costs would be more logically and accurately reported on Form 5 as part of the subcategory "Infrastructure." Administrative functions contribute to state-level MCH infrastructure by needs assessment, planning, policy development, monitoring, building information systems, etc.

B. Budget

Much of what is requested for budget narrative has already been described in the Expenditure narrative with budget features addressed and clarified as they relate to expenditures. Our determination to make a shift in the framework is due to the inextricable relationship of budget and expenditure, and our interpretation that statutory "maintenance of effort" and "earmarking" requirements are based on expenditures. The guidance and forms mistakenly connect these requirements to budget. The Guidance for Section V. "Budget Narrative" confuses these distinctions by instructing the expenditure narrative to precede budget narrative. Logically, expenditures are "subsequent to" budget. If the heading was changed for Section V. to "Financial Narrative" it would be more descriptive of the section content that is inclusive of budget and expenditures.

Budget and expenditures are necessarily intertwined. Understanding the particular function of budget and expenditure are important for accountability and compliance with statutory requirements. It is not the intent to minimize the purpose of budgeting, although we believe it is responsible to emphasize our understanding that accountability is entirely related to expenditures. Expenditures, of course, are legitimized by a realistic budget.

An introductory statement in the instruction to budget Form 2 states: "This form provides details of the State's MCH budget and *the fulfillment of certain spending requirements* under Title V for a given year." (Emphasis added.) Contrast budget as a plan for expenditures with actualization being the expenditure of funds based on the budget. The fulfillment of spending requirements, i.e. "earmarking" and "maintenance of effort", comes with expenditure; it is not a direct result of budget alone. If compliance for earmarking and maintenance of effort were based in budget, although they are not, Form 2 would be further misleading. Due to its limitation to budget carryover (see Expenditure narrative for detail), the earmarks in Form 2 are percentages of the budgeted allotment, rather than the budget of allotment plus carryover.

Amount, source, and time period are critical components in budget and expenditure. Form 2 seeks a budget overview of funds, including "other federal funds" under the control of the person responsible for the administration of Title V. The format does not allow for subsequent report of actual expenditures of the budget amount of "other federal funds." Further, some of these "other federal funds" do not mirror the Title V fiscal year period of October 1-September 30, making it difficult to accurately understand the financial relationships between the various sources and amounts of funds to Title V.

Federal Title V support clearly complements Nebraska's effort. Nebraska's budgeted "maintenance of effort", based on FY 1989 State support, has consistently been surpassed. The source of non-federal funds is a combination of State Comprehensive Systems and local funds and in-kind support to meet both maintenance of effort and the 3:4 match requirement. The largest single source of State support comes through the Medically Handicapped Children's Program (MHCP). Other sources of State funds that complement Title V funding include support to the following: the Immunization Program for vaccine purchase, Public Health Screening, Birth Defects Prevention legislation to support genetic clinics at the University of Nebraska Medical Center, and Newborn Metabolic Screening Program which also includes a cash fund from screening fees.

The inadequacies of the financial forms to produce meaningful and accountable information, is further demonstrated between Form 2, Form 3 and Form 4. Compliance with the 30-30-10% earmarks is suggested on Form 2 budget, although we interpret the statutory earmarking

requirements as the expenditure of allotment. The expenditure of the federal allocation (Form 3) is shown separate from the earmarked categories of expenditures on Form 4, which are a combination of federal and state funds. Form 4 cannot be used to determine earmarking compliance, as that is based on the federal allotment alone. Form 5 is also plagued with similar problems as Form 4, although not in the same statutory compliance since the Form 5 categories are not earmarked. (See Expenditure narrative regarding Form 5 relative to administrative cost and infrastructure.) If administrative costs were incorporated on Form 5, as suggested, Form 5 would need to identify the distinction between budget for federal and state funds relative to the 10% earmark. A clearer definition of "administrative costs" is needed.

We believe the intent of the financial narrative is to explain any significant budget-to expenditure variations. However, as detailed above, it is difficult to discern those variances in the present format and instructions, creating extreme limitations to our ability to meet what we believe is the intent of this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.